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University Co-operation

ONE aspect of nursing education in the United States and Canada which always interests nurses from this country visiting North America is the number of collegiate schools of nursing and postgraduate nursing degrees offered by various universities. Reports of investigations and studies of the nursing position in the United States have come out very strongly in some instances in favour of degree courses as the future basic preparation of the professional nurse, and at least one investigation suggested that such courses should eventually replace the qualification of 'Registered Nurse'. It has also been widely proclaimed that the university course should not be narrowly vocational but that the professional subjects should be integrated into a more liberal programme.

Opinion in this country is certainly divided on the question of the value of a basic degree in nursing, although few would disagree with the idea that an arts or science degree taken before the professional training must benefit the individual eventually in her professional life. Some of those who feel that a collegiate course leading to a degree would be an experiment worth trying do not of course always take into account the problems involved in such a step. Obviously the universities in this country would be neither willing nor able to open their doors to large numbers of nursing students. The numbers of students entering universities is rising and the available space and staff may well be a problem. A vocational degree may conflict with the established policy of the university, although a study of the programmes shows that many offer a general degree in arts or science with a definite specialized bias, for example the 'B.Sc. Estate Management' and the 'Bachelor of Pharmacy' degrees of the University of London.

The Royal College of Nursing, writes Miss Marjorie Houghton, M.B.E., chairman of the Education Committee, has had links with a number of universities for many years and co-operation has been particularly close with the University of London which has conducted the Diploma in Nursing Examinations continuously since 1927 and, since 1947, the Sister Tutor Diploma examinations. These are, however, specialized postgraduate courses and the Royal College of Nursing has always had in mind the introduction, in the right way and at the right time, of a course leading to a degree. In 1947 the Council of the College asked its Advisory Board on Nursing Education, of which Sir Cyril Norwood was at that time the chairman, to consider the question. The view of the Advisory Board was that it would in principle be proper for the College to sponsor such a course and the Board embarked upon a study, which is still proceeding, of the problems involved.

In its deliberations the Advisory Board first considered the factors which had led to a demand for a degree course allied to nursing. The reasons put forward were, in the main, concerned with the rapidly increasing scope and responsibility of nurses in the hospital and the public health services, in government departments and in national and international organizations, and with the need for the widest and best possible education for those members of the profession who would in the future fill these posts. It was also pointed out that entry to the nursing profession through this avenue would tap a numerically small but valuable source of recruits who would not otherwise be attracted to nursing. It was considered that the desire of a number of intelligent and ambitious nurses to embark upon a degree course at a later stage in their career was evidence that they felt the need for a more liberal preparation for the work that they were undertaking than that provided by the basic nursing training with the addition of post-registration courses.

Probing into the methods whereby some trial scheme might be launched is inevitably a slow process and every step requires the most careful consideration. Approaches to individual universities for advice and discussion have always been received most sympathetically, but every university has a paramount duty of safeguarding the standards of higher education and has to be convinced that

At the PUBLIC HEALTH SECTION RESIDENTIAL CONFERENCE held at Beaumont Hall, Leicester. Dame Enid Russell-Smith and Dr. J. Stanley Thomas, centre, with Mrs. A. A. Woodman, M.B.E., Miss E. M. Wearn and other nurses attending the conference.

any new course which it may sponsor has something to offer to as well as something to get from the university. It seems that the correct line to pursue is to try out a course, under the auspices of a training institution, which if it proves a success may then be offered to the university for inclusion in the degree programme.

If the nursing profession seeks the establishment of such an experimental course it should ensure that in the initial stages the control of the educational content of the course is not lightly abandoned to any outside body. It would seem that a good balance between sound academic teaching on a liberal basis and equally sound clinical teaching could be attained by co-operation between the Royal College of Nursing and other colleges, schools of the university, and one or more hospital training schools. Consideration of the content of a course seems to point quite logically to the fact that it would fit more closely with the type of studies required for students in a faculty of social studies than into any other existing course. In view of the increasing recognition of nursing as a social service this is not surprising.

Further consideration of the problem, and the advice of those best qualified to offer it, suggests that the Royal College of Nursing should undertake the pioneer task of establishing a course of social studies allied to nursing and integrated with a basic nursing course. The educational standards of those accepted for such a course would have to meet university entrance standards and the course would undoubtedly be a strenuous one even for students of the highest calibre. Financial problems are also likely to prove difficult to solve. Such an experiment if it could be sponsored by the College would have the most valuable results not only for the few who could undertake it but also because this educational venture should eventually shed a great deal of light on desirable future trends in nursing education.

No one would venture to suggest that the basic nursing course for all entrants to the profession should ever be a degree course, nor that such a course produces a nurse who is necessarily more skilful; but we might well find that properly used it would give us women whose abilities have been fully developed and who therefore make a contribution to their profession and to the community that is of benefit to all.

TOPICAL NOTES

Royal Colonel-in-Chief Q.A.R.A.N.C.

THE WAR OFFICE announced last week that the Queen had given orders for the appointment of Princess Margaret as Colonel-in-Chief, Queen Alexandra's Royal Army Nursing Corps. Since 1902 when the (then) Queen Alexandra's Imperial Military Nursing Service was established by Royal Warrant, the military nursing service has always enjoyed the close interest and support of the Royal family. Queen Alexandra was its first President, and Queen Mary became President in 1926. In 1948 Her late Majesty became Commandant-in-Chief and, on the formation of Queen Alexandra's Royal Army Nursing Corps in 1949, became its Colonel-in-Chief, which appointment she retained until her death in 1953. Her Royal Highness Princess Margaret, C.I., G.C.V.O., has now graciously consented to accept the Colonelcy-in-Chief vacant since Queen Mary's death.

Conference at Leicester—

SOME 50 PUBLIC HEALTH NURSES holding senior posts in all parts of England attended a most inspiring residential conference arranged by the Public Health Section of the Royal College of Nursing at Beaumont Hall, one of the delightful residences of the University College of Leicester last weekend. In the glow of the late summer warmth and sunshine the gardens of Beaumont Hall, famous for their beauty, made an enviable setting for this happy gathering. The tone of the conference was set by three excellent speakers on *Opportunities and Obligations in the National Health Service*. Miss Freda Young, M.A., J.P., head of the Department of Social Studies, University of Southampton, in the inaugural address on Friday evening, October 1, gave an illuminating outline of the art and skill of social casework. Dame Enid Russell-Smith, Under-Secretary, Ministry of Health, discussed the administrative position today in the light of developments since 1948. In the afternoon Dr. J. Stanley Thomas, M.R.C.S., L.R.C.P., J.P., general practitioner, East Ham, showed from his own wide experience of co-operation with the nursing profession how essential that co-operation is in the day-to-day work of doctors and health visitors with patients and their problems.

—with Group Discussion

THE FIVE DISCUSSION GROUPS were led by Miss M. Witting, superintendent nursing officer, Lindsey Division of Lincolnshire; Miss P. O'Connell, health visitor tutor, University of Southampton; Miss E. Westwater, superintendent nursing officer, Doncaster; Miss D. K. Newington, deputy superintendent health visitor, Buckinghamshire County Council, and Miss J. M. Akester, superintendent health visitor, City of Leeds. From reports given by representatives of each group at the closing session it was clear that the challenges of the several speakers had been accepted and freely debated. The findings of the groups, together with salient points from the three main addresses, were brilliantly summarized by Miss E. M. Wearn, chairman of the Public Health Section, who acted throughout the conference as hostess with the assistance of Mrs. A. A. Woodman, M.B.E., and Miss E. Robinson, chief nursing officer, London County Council. At an informal dinner party the following guests were also welcomed: Dr. R. J. F. Pinsent, representing the College of General Practitioners; Dr. E. B. Berenice Humphreys, maternity and child welfare medical officer, Leicester City; Dr. Gladys Randall, senior school medical officer, Leicester City; Miss Marjorie L. Campbell, senior assistant county medical officer, Leicestershire; Miss G. E. Prior, matron, Leicester General Hospital, and president of the Leicester Branch, Royal College of Nursing. Mr. W. S. J. Payne, clerk of the Leicestershire and Rutland Executive Council, and Miss K. Drage, public health regional nursing officer, Ministry of Health. The three main addresses will be published later.

Matron, Manchester Royal Infirmary

MISS BARBARA JEAN WYLIE, S.R.N., S.C.M., Diploma in Nursing, University of London, Sister Tutor Cert., Royal College of Nursing, has been appointed to succeed Miss L. G. Duff Grant, R.R.C., as principal of the United Manchester Hospitals School of Nursing and matron of the Manchester Royal Infirmary; she will assume her new duties on February 1, 1955.

Miss Wylie, who has been deputy matron, Westminster Hospital, London, since October 1951, took her general training at King's College Hospital and midwifery training at Queen Charlotte's Hospital, London. She joined the staff of King's College Hospital in June 1939 as staff midwife and remained at her training school until she took up her present appointment, being assistant night sister, ward sister, sister tutor in charge of the preliminary training school and administrative sister. Miss Wylie will bring to her new responsi-

Right: nurses leaving Waterloo Station to join the 'Carnarvon Castle' for the tour arranged by the National Council of Nurses of Great Britain and Northern Ireland at the kind invitation of the South African Nursing Association, with (extreme left) Miss G. Ellis and (centre) Mr. P. Fourie from South Africa House who were at the station to wish them well.

bilities a rich experience and enthusiasm worthy of this important appointment, upon which we offer her our congratulations and good wishes. Miss Elsie Jacob, a trainee of Westminster Hospital, and now assistant matron, Bristol General Hospital, is to follow Miss Wylie as deputy matron, at the Westminster Hospital.

Annual Exhibition

THE LONDON NURSING EXHIBITION, held annually at Seymour Hall under the auspices of the *Nursing Mirror*, is to be opened on Monday, October 11, by Lady Churchill, G.B.E.; the President of the conference this year is Sir William Gilliatt, K.C.V.O. The list of lectures and films appears on page 1095. Readers will be very welcome at stand B1 where the *Nursing Times* representative will be pleased to answer inquiries and supply copies of the journal, special reprints, or subscription forms for new readers.

British Doctors Visit Russia

REPRESENTATIVES of the medical and nursing press were invited to meet members of the party of 19 British medical workers who recently returned from a visit to the Soviet Union at the invitation of the Soviet Minister of Health. The tour had been arranged with the assistance of the Society for Cultural Relations with the USSR, though not all members of the delegation are connected with the Society. Among the delegates were Lord Amulree, Professor Esther Killick, Dr. A. Comfort, Dr. T. F. Fox (Editor of *The Lancet*) and Dr. C. H. C. Toussaint. Spending their first week in Moscow, the British party met officials of the Ministry of Health and of the Academy of Medical Science; they then visited other cities and centres in smaller groups.

Though medical service is free, it was learned that patients pay for all medicines prescribed for them, certain expensive drugs and preparations, such as aureomycin, being subsidised to bring the charge down to a reasonable figure, while ordinary drugs are dispensed at cost; those suffering from diabetes or tuberculosis are supplied with drugs free of charge. Private medical practice exists only to a very limited extent in Russia; there is a wide range of salary scales for those paid by the State, with pensions payable after 25 years of service, or at the age of 55. Postgraduate study is regularly provided for all doctors at stated intervals and free of cost. All appointments are on a five-year basis, renewable if the holder is suitable and wishes to be re-appointed. Copies of the medical press seen by the visitors were said to be packed with advertisements for senior posts; young doctors, on qualifying, are interviewed by groups of people seeking to give employment and are thus selected for work in posts where they are needed for a period of three years.

An attempt to discover something of the doctor/patient relationship revealed that in general a group of doctors serves a given area and patients attending a polyclinic near their homes would be seen there by one of the doctors who would also visit them at home when necessary. It was evident that members of one family might attend different polyclinics, since there are separate ones for children, and husband or wife may attend the polyclinic at the factory where they work.

The visitors were much impressed by the almost extravagant scale on which sanatoria and health resorts are provided and equipped. Some of those seen were built 300 ft. above the Black Sea, each having its own funicular railway down to the water-front. These institutions are run by the trade unions who also pay 70 per cent. of the cost to the patient, who has the additional help of subsidised fares.

In the field of psychiatry it was found that treatment favoured the school of Pavlov, with no recourse to psycho-analysis, which in the opinion of the Soviet doctors is unscientific, or to leucotomy. At a 1,000-bed mental hospital visited near Moscow there were no less than 40 members of the medical staff. Here the patients were interviewed individually at 'explanatory sessions' and were then treated with insulin, electric shock, pyrexia or sleep therapy. There appeared to be no equivalent to our system of certification, patients being admitted to hospital as necessary or kept at home under treatment when possible. It was claimed that conditions treated by psychiatry were diminishing and for this it was felt that credit must be given to the wide opportunities provided for therapeutic holidays.

The hospitals seemed to be friendly places, with a good attitude to the patients and an atmosphere of being less rushed than our own. A feeling of confidence and a good relationship had been observed between a surgeon, patient and anaesthetist during an operation performed under local anaesthetic. On one occasion a member of the visiting party had been invited to perform an operation before an assembly of local surgeons.

The visitors seemed to have had little opportunity to assess the nursing position. There was thought to be a ratio of "one trained nurse to about 15 hospital beds, with any number of unqualified medical auxiliaries", but though nurse training schools were known to exist none had been visited, nor had the presence of nursing administrators been noted in the hospitals visited. It seemed that authority was in the hands of the medical profession for all staff.

Among general impressions it was said that the most exciting experience of all had been that of visiting Russian colleagues in their own homes, which had done much to promote mutual friendship and confidence.

Contents

	PAGE
UNIVERSITY CO-OPERATION	1085
RADIO-IODINE IN MEDICINE	1088
BOOK REVIEWS	1090
BARRIER NURSING AND NON-TOUCH TECHNIQUE IN DOMICILIARY NURSING	1091
INDUSTRIAL OPHTHALMOLOGY	1093
LONDON NURSING EXHIBITION PROGRAMME	1095
RECENT ADVANCES IN THE INVESTIGATION AND TREATMENT OF HEART DISEASE	1097
HYPOTHERMIA IN CARDIAC SURGERY	1100
ADRENALECTOMY: A CASE STUDY	1102
EDUCATIONAL BACKGROUND OF THE NURSE	1105
FLORENCE NIGHTINGALE (serial)	1106
IN A HOSPITAL FOR NERVOUS DISORDERS	1108
FOUNDERS OF LONDON HOSPITALS	1109
ROYAL COLLEGE OF NURSING NEWS	1113

RADIO-IODINE IN MEDICINE*

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THE role of radio-iodine in medicine depends on the physical properties of this isotope and the special relationship of iodine to the thyroid gland.

There are several varieties, or isotopes, of iodine which differ in their atomic structure. The isotope used in medicine has an atomic weight of 131 (natural iodine has an atomic weight of 127) hence the symbol used for it is I^{131}. It is a fission product of the atomic pile and can be prepared free from other radioactive materials and natural iodine. The isotope has an unstable atomic structure so that the atom will disintegrate to release radiation of a character akin to X-rays. The intensity of the radiation will depend on the number of atoms disintegrating, and as time passes the intensity diminishes as the number of atoms left gets progressively smaller. The speed of disintegration is constant, the radiation of any sample being halved in eight days. Thus one talks of the isotope I^{131} having a half-life of eight days.

Although I^{131} is an unstable atom it behaves exactly like natural non-radioactive iodine until the moment of disintegration. Therefore the human body does not distinguish between the varieties of iodine. By following the passage of a group of radioactive iodine atoms around the body one gets exact knowledge of what happens to natural iodine. It is like tying a label on iodine and seeing how the body deals with it.

Diagnostic Methods

The whereabouts of radio-iodine in the body or its excretion can be determined by measuring the amount of radiation in any particular part. The intensity of radiation recorded will be proportional to the amount of the isotope present in the specimen. The apparatus used for measurement is the Geiger-Muller counter. The principle of this device is simple, despite the practical complexities of the construction. A critical voltage is applied to two electrodes enclosed in a vacuum tube. Any radiation entering the tube increases the energy already applied to the electrodes until a pulse of current passes. This impulse is amplified and recorded by an electronic 'counter'. By counting the number of pulses in a given time the intensity of the radiation is measured and can be related to the dose administered by counting a 'standard' from it. Another device for recording radiation is the scintillation counter. In this radiation passes through a specially made crystal which emits a tiny flash of light when it receives the radiation. The flash is amplified and converted to an electrical impulse which is counted as for a Geiger-Muller counter. Counters of both types are designed for their especial roles in recording radiation from various parts of the body, or in urine or blood.

Iodine forms an integral part of the hormone elaborated by the thyroid. The amount of iodine present in the blood is minute so the thyroid has an efficient 'trapping' mechanism which concentrates iodine in the gland far above the blood concentration. Directly the iodine has been concentrated in the thyroid other enzyme systems incorporate it into the various stages of hormone synthesis. Thus it becomes bound into the hormone molecule which is stored in the colloid of the thyroid and eventually released into the circulation. On reaching the tissues the molecule is broken down, liberating the iodine which begins its cycle once more. Iodine which is not taken into the thyroid is excreted by the kidney. Thus the two important sites for studying the passage of iodine are the neck and the urine.

The dose of radio-iodine used for diagnostic procedure is 10-50 microcuries. This represents an infinitesimal amount of iodine in terms of weight, and the radiation is not sufficient to affect the thyroid. Indeed the amount of radiation which the whole body receives is not more than that from a thorough barium meal X-ray examination. It is obvious that the radiation hazard must be considered whenever a patient is investigated by radioactive iodine techniques, and the dose kept to a stringent safety level. Unnecessary and repeated tests must be avoided.

The major diagnostic role of radio-iodine is in thyrotoxicosis and myxoedema. The alterations of thyroid function responsible for these diseases can be gauged by the abnormal manner in which I^{131} is handled by the gland. Technical details vary in the diagnostic procedures but the majority of tests depend on following the distribution of I^{131} immediately after its ingestion. In thyrotoxicosis the thyroid accumulates I^{131} at an exceedingly high rate and to a much greater extent than normal. Measurement of radiation from the neck region will demonstrate this rapid rate of accumulation and high total I^{131} content. This measurement can be compared with the falling concentration of I^{131} in the blood or in muscle (the concentration here is similar to that of blood).

All measurements over the thyroid are subject to variations in the anatomy of the neck and thyroid. Consequently the counter has to be carefully screened with lead and its position in relation to the neck rigidly standardized. The normal values for each type of test have to be determined on people without thyroid disease. The values obtained are expressed as rate of uptake, total uptake in 24 hours, or neck-calf ratio. In thyrotoxicosis all these values are increased markedly. In myxoedema the thyroid takes up radio-iodine at a slower rate than normal, and the total amount accumulated is less than normal. Similar tests are used, but the slower working of the thyroid is made more obvious by taking the measurements over a longer period of time than is required for the detection of thyrotoxicosis.

Alternative Tests

Another method of achieving the same diagnostic result is by measuring the amount of I^{131} excreted in the urine. In thyrotoxicosis a small percentage of the tracer dose is excreted because of the increased accumulation of iodine by the thyroid; similarly in myxoedema the majority of the dose is excreted in the urine. A refinement of the method is to measure repeated samples of urine so that a pattern of excretion can be determined, and, by calculation, the rate of thyroidal iodine accumulation is found. Urinary measurements are subject to variations in renal function, although these can be allowed for by calculation. The major difficulty is ensuring a correct collection of urine. The nursing staff can be of great help by supervising a full collection of specimens as required for the test.

It is apparent that the tests described give a limited view of thyroid function. They all depend on the iodine trapping power of the gland. But apart from a few exceptions, variations in iodine-trapping ability are a true reflection of total thyroid function. However, it is possible to use a different approach by measuring the amount of radio-iodine which becomes attached to protein in the blood: if this is estimated 48 hours after the dose of I^{131} is given, the protein-bound radio-iodine indicates how much hormone has been synthesized and released by the thyroid. The levels

**Abstract of a lecture given at a special course for ward sisters at the Royal College of Nursing.*

are so low that accurate recording is difficult but it is valuable in the diagnosis of thyrotoxicosis for the amount is increased in this disease and physiologically speaking the increase of circulating hormone should parallel the severity of the disease. The best way of gaining diagnostic information is to perform a whole battery of tests after the one dose of I^{131}. This is not necessary in the vast majority of cases of thyrotoxicosis or myxoedema but becomes vital in recognizing the rare disorders, such as certain types of goitrous cretins whose thyroids can trap iodine but fail to make the normal hormone.

Certain precautions are very necessary before performing any diagnostic study with radioactive iodine, and nurses should be aware of these. The administration of iodine in any form prior to the test will entirely invalidate the result, because as little as 2 mg. of iodine will upset the iodine cycle of the thyroid. Some investigators insist on a special low-iodine diet but this is not strictly necessary if the patient is eating a normal diet. However, it is imperative that the patient has not had iodine in any medicinal form for at least three weeks before the test. Apart from the obvious case of Lugol's iodine, there are the various iodide-containing cough mixtures, cough lozenges and ointments. Iodine solutions on the skin have the same effect, and the most prolonged effect arises from iodized solutions used in radiography. At least three weeks should elapse between the cessation of iodide administration and the performance of any I^{131} tests. It may be many months before a test is worth while after bronchography. Other anti-thyroid agents, such as the thiouracil group of drugs, and thyroid extract or thyroxine, invalidate a diagnostic test and must be discontinued about three weeks before the giving of radio-iodine.

Radio-Iodine Therapy

Thyrotoxicosis

Thirty-five years ago the most popular treatment for thyrotoxicosis was the application of radium to the neck. Sufficient radiation reached the thyroid to cause involution and destruction of the cells with diminution of thyroid function. Despite the cure of thyrotoxicosis by this method the use of radium (and deep X-ray therapy) was abandoned because of the severe skin reactions which resulted. The problem was to deliver an effective dose of radiation to the thyroid cell without affecting surrounding structures. The solution lies in the use of radio-iodine which enables the thyroid cell to be irradiated from within itself. Extra-thyroidal radiation is at a minimum, because the isotope is rapidly eliminated by the kidney. Practical experience has shown that radio-iodine does cause a return to normal thyroid function in cases of thyrotoxicosis without subjecting other parts of the body to a marked radiation hazard.

The evaluation of radio-iodine therapy must be made in comparison with the excellent results obtained by other treatments of thyrotoxicosis. Subtotal thyroidectomy after careful premedication has achieved a high percentage of long-term cures at little risk when performed by the specialist surgeon. It is not a question of having one method of treatment but selecting the right method for the individual patient.

Experimental work suggests that there is a slight but definite risk of radio-iodine causing cancer of the thyroid to arise 20 or more years later. There is also a slight risk of genetic defects occurring in the patient's ovum or spermatozoa. These risks are undoubtedly small, but it is usual to adopt the convention that radio-iodine therapy should not be given to any patient under the age of 45 years, unless alternative treatment is likely to be unsatisfactory or dangerous. Such an age convention is a useful check on the indiscriminate use of radioactive materials. Radio-iodine therapy is completely without any immediate risk and can be used for all patients of 45 years or over, provided the thyroid is not causing obstructive symptoms. It is particularly indicated in all cases of thyrotoxicosis with cardiac involvement, and in recurrent thyrotoxicosis previously treated by thyroidectomy. Any patient who is a bad surgical risk or is intolerant of anti-thyroid drugs should be considered for radio-iodine therapy. Lastly it appears to be the safest treatment in thyrotoxicosis associated with progressive exophthalmos. Thus radio-iodine plays an important part in the treatment of thyrotoxicosis and must be considered as complementary to other forms of therapy.

The most difficult aspect of the treatment is determination of the right dose for each patient. The major factors concerned are the ability of the thyroid to trap and retain iodine, and the size of the gland. One can only make a shrewd guess at the latter. The clinical severity of thyrotoxicosis will parallel roughly the activity of the thyroid, and its avidity for iodine. Hence there is a physiological adjustment of the therapy dose, for the more active the cell the more radiation it will receive by virtue of its increased ability to trap iodine.

If all thyroids were of equal size it is probable that a standard dose of I^{131} would be suitable for the majority of thyrotoxics. However, the larger thyroids will require a larger dose. In practice the average dose is 10 millicuries, varying from 7 to 12 millicuries. The dose is given by mouth, just as for the tracer dose. The aim is to effect a cure of thyrotoxicosis by one administration of radio-iodine. The action is relatively slow but achieves its maximum in about three months. A period of mild transient hypothyroidism may occur at that time. If the patient still has evidence of residual thyrotoxicosis four months after treatment, a further dose of radio-iodine is indicated.

The amount of radio-iodine excreted in the urine after a therapeutic dose is sufficient to constitute a radiation hazard. Therefore all the urine must be collected for at least 48 hours after the dose. It is wise to use a marked bed-pan for this and for nurses to wear rubber gloves when handling the bed-pan or urinal. The urine has to be kept in a metallic container until its activity has diminished considerably. The disposal of the urine is the responsibility of the physicist, who must also be informed of any urine spillage that may occur.

Thyroid Carcinoma

The treatment of thyrotoxicosis by radio-iodine has gained an undoubted place as an effective and safe method. It is unfortunate that the treatment of thyroid cancer by this istotope has not produced such clear-cut results. The crux of the problem lies in the ability of the more malignant anaplastic carcinomas to trap iodine. The less malignant type of growth preserves some of the ability of the normal thyroid to concentrate iodine. But a very high concentration of radio-iodine is needed in the malignant cell before it can be destroyed by radiation. This cannot be achieved as long as the normal thyroid is competing successfully against the cancer for the dose of radio-iodine. Therefore the thyroid must be destroyed before the cancer can be treated. Destruction can be by surgical removal or ablation by radio-iodine. Then radiation of the cancer can be attempted.

Provided the radio-iodine is taken up by the carcinoma, either in its primary site or its metastases, the results are good. So for a limited number of cases a new effective method of treating thyroid cancer is available. As in the therapy of thyrotoxicosis, careful collection and disposal of urine is necessary. The radiation hazard of urine following the treatment of thyrotoxicosis is small compared to the massive excretion of radio-iodine after the treatment of a carcinoma, where the dose is larger and a much smaller percentage of it is retained in the body. It is wise to keep up the patient's fluid intake, and ensure that the urine is passed frequently. An additional safeguard is to remove the patient's dentures for 48 hours to prevent an accumulation of radioactivity under the denture, as some I^{131} is secreted in the saliva.

This review has attempted to show that radio-iodine has a great part to play in the diagnosis and treatment of thyroid disease. No mention has been made of its role in research. But its present applications in medicine follow logically from its role as a research tool, and advances in the future will come as a result of the current research programme which utilizes radio-iodine in many chemical and biological experiments.

BOOK REVIEWS

Occupational Health

(Survey of Govan Ward, Glasgow, 1953).—*by Dr. Stuart I. A. Laidlaw and Dr. James H. Bell. (Obtainable from the Medical Officer of Health, Glasgow.)*

Any constructive thinking about the provision of an occupational health service is to be warmly welcomed. The approach in this survey is particularly valuable, in that consideration is given to the needs of an area as a whole; the intention being to observe the health problems of shops, schools, libraries, cinemas, offices and, in fact, any place of employment, alongside those of the industries in the area. The survey was undertaken as part of a series of investigations instituted by the Occupational Health Committee of the British Medical Association, in consultation with the Society of Medical Officers of Health. Govan Ward of Glasgow was considered a suitable sample of an industrial area in a city.

"The aim of the survey was to determine to what extent an occupational health service was necessary in the area, and how best it could be organized."

In form, the survey presents a brief description of the area in relation to housing, transport and amenities; then the industrial and non-industrial types of employment are indicated. The existing medical services, industrial and non-industrial, are listed and the report goes on to present some comments on working conditions. The environmental survey is supported by two maps, one of Glasgow showing the position of Govan Ward, and the other a detailed map of the ward showing the industrial establishments. There are also two tables; one shows the size of the factories, grouped according to the type of industry; the other shows the grouping of shops according to merchandise sold. The latter gives some indication of the ventilation, heating, lavatory accommodation and washing facilities available. There is no comparable assessment for the industries.

The report states: "this survey has produced convincing proof of the need for an occupational health service in this area", but nowhere are the criteria used to assess 'need' made explicit. From the report, it is evident that a large number of people are employed in the area; just how large it is difficult to say because the relationship between the numbers given in the text and those given in the tables is by no means obvious. It is moreover clear that the existing medical services for industry are slender and that the environmental conditions in the shops, offices and factories could be improved. Certain health hazards were found, but whether in the factories with or without medical supervision is not stated. The conditions under which food is handled obviously leave much to be desired. No indication is given as to the methods of investigation employed. It would have been interesting to have known the extent to which the records in the offices of the local health authority and the factory inspectorate were used and the amount of on-the-spot investigation which was undertaken specially for the purpose of the survey. It seems likely that much of the information could be secured from existing records.

The second object of the survey was to determine how best an occupational health service could be organized. Certain canteens are already shared by different firms and it is said that these sites could serve as sub-areas, presumably for medical centres. Other sites are indicated as being suitable, but whether for canteens or medical centres or both is not clear. For shops and offices, medical centres based on doctors' surgeries are suggested. The need for pre-employment examinations, and for advice on personal hygiene to workers, and on environmental hygiene to management, is recognized but the report never gets to grips with any details concerning the means by which these undoubtedly desirable ends could be achieved. The intention is apparently to use the local general practitioners, the medical officer of health and the existing industrial medical officers, in some sort of combination.

This section appears to have been put together hastily without due consideration of the body of knowledge which has already been built up on occupational health work in general and group schemes in particular. Perhaps the advisory committee, which it is proposed should be set up, may do something to rectify this, for on it are to be represented management and trade unions of the area and the medical inspector of factories as well as local medical practitioners, the medical officer of health, and nursing representatives.

On the asset side, the report shows that the occupational health service envisaged is to be a service for the prevention of ill health not only for workers employed in large undertakings but for those in all types of employment. Moreover, although the plans are very sketchy, the idea of utilizing and co-ordinating existing medical services for the benefit of all employed persons is kept well to the fore, and the need for doctors and nurses to have additional training if they are to undertake these added duties is clearly recognized. Education of employers and employees in the correct use of such a service is stressed and their co-operation is wisely being sought from the outset on the advisory committee, which it is to be hoped will enable this seemingly rather barren report to bear fruit in due season.

H. M. S., S.R.N., Industrial Nursing Cert.

Anatomy, Physiology and Hygiene

A Textbook for Nurses (fifth edition).—*by A. Millicent Ashdown and E. Bleazby, Diploma in Nursing, University of London, with a foreword by George F. Stebbing, M.B., B.S., F.R.C.S. (J. M. Dent and Sons, Limited, Aldine House, Bedford Street, London, W.C.2, 10s. 6d.)*

Many readers will already be familiar with this combined work which was first produced in 1935 and at that time was a very useful book for nurses studying for the preliminary State examinations.

The anatomy and physiology section still remains fairly complete and has some very good diagrams. The second part on hygiene does not really stress the importance of personal and communial health and the preventive aspect of disease. Only a few lines are given to public health and very little mention is made of the health services of the country.

There is a very complete chapter on the vitamins which is rather more detailed than the rest of the book attempts to be. At the end there is a section on blood transfusion and blood grouping which is unusual for such a book as this and would be better for the nursing textbooks.

On the whole this book would be best recommended for reading by students before they enter the preliminary training school. Nurses in training would be better advised to use other standard textbooks that treat each subject separately.

B. T., S.R.N., S.C.M., S.T.Cert.

Hospital Bed Occupancy

A Report of the First Study Group set up by the Administrative Staff College.—*(Obtainable, free, from King Edward's Hospital Fund for London, 10, Old Jewry, London, E.C.2.)*

Not everyone will know that there is a Hospital Administrative Staff College, maintained by King Edward's Hospital Fund. This College organized a special group to study the subject of hospital bed occupancy, and their findings have now been published. The members of the study group were all senior administrative officers, hospital administrative officers, or medical men particularly interested in the subject.

The report is based mostly on hospitals in greater London, excluding the teaching hospitals, though many of the findings and suggestions are applicable to hospitals everywhere. The report mentions that, at any rate in greater London, recent changes in the density of the population not paralleled by changes in the sites of hospitals are to a large extent responsible for long waiting lists at some hospitals, and short lists at others. The fallacy of the commonly used percentage bed occupancy is pointed out, and the plea made for the 'turnover interval' instead. Among the many suggestions for reducing the turnover interval is greater flexibility of bed allocation; the booking of investigations in advance, and, in cases where it is possible, consultants who

use several hospitals admitting to one with a short waiting list rather than to a hospital where the waiting list is long.

The report is concise and well written and can be thoroughly recommended to all administrative officers and to all those of the nursing and medical profession interested in this subject, though, understandably, it holds little appeal for the nurse more interested in clinical nursing than in the administrative side.

V. E. L. H., M.R.C.P.

Do Cows Have Neuroses?

(*Copies of this booklet may be obtained from the National Association for Mental Health, 39, Queen Anne Street, London, W.1, 1s. 6d.*)

This 16-page pamphlet, an adaptation of a publication (presumably with the same unfortunate title) produced by an American mental hygiene organization, is an attempt by the National Association for Mental Health to bring information about this important subject to the non-psychiatrically orientated layman.

Much of the material, couched in simple, non-technical language, is excellent. In one page the reader is shown five of the basic essentials which go to make up the well-balanced and happy human being. It is indeed refreshing to find such fundamental tenets as the need for love and for freedom, for discipline and for acceptance, given their true importance.

As a source of preliminary information and to arouse the interest of those working in fields where mental hygiene understanding is very important this pamphlet could serve a useful purpose; those concerned with nursing and the law, members of voluntary societies and church workers, could all gain understanding from the greater part of the material of this booklet; indeed the American publication was introduced as " written by a layman for laymen ".

It is doubtful, however, whether the rather genial approach to a very heavily charged subject, the repetitious strip-cartoon technique, or the peculiar title will inspire either the mentally-ill or their relatives to that further exploration of the subject which is the avowed object of the pamphlet.

C. C., Psychiatric Social Worker.

Books Received

Gynecology and Gynecologic Nursing (third edition).— *by Norman F. Miller, M.D., and Hazel Avery, A.B., R.N., with a chapter on the Gynecology Operating Room by Molly Kowal, R.N., and a chapter on the Psychosomatic Approach in Gynecology by Sprague Gardiner, M.D.* (*W. B. Saunders Co., 24s.*)

Barrier Nursing and Non-Touch Technique in Domiciliary Nursing

by E. S. CLEWES, S.R.N., S.C.M., H.V.Cert.,
Queen's Nurse, District Nurse Tutor, East London Nursing Association.

BARRIER nursing, as the word implies, consists in the adoption of certain nursing procedures in order to prevent the occurrence or spread of infection. The home nurse will, in the course of the day's work, be caring for a variety of patients with as great a variety of illnesses and therefore this prevention of the spread of infection must be one of her most important considerations. She will not only need to realize the needs of the patient but also of the family among whom he lives and in the light of this close relationship preventive measures will have to be considered within the family group. The home nurse, too, will need to protect herself as a precaution against contracting the disease.

Unless adequate precautions are taken the home nurse can spread infection to other patients, other members of the family and herself through:

(*a*) her skin—if it has become contaminated with the patient's excretions or discharges;

(*b*) her clothing—if contaminated with discharges;

(*c*) infected articles—such as the nursing bag and its contents.

Prevention of Infection

(*a*) *Nursing procedures.* In order to prevent such possible infection a barrier nursing outfit is always used when caring for the patient. It consists of a bag containing an overall, cap, tin of masks, Dettol, thermometer, pulsometer, nail brush, soap, towel. This equipment is left at the patient's home and used exclusively for him. It is kept immediately within or outside the patient's room depending on conditions in the home.

The nurse's outdoor clothes and nursing bag are left outside the sickroom, for no part of the patient's room can be considered free from infection. The actual zone of infectivity is estimated to be from 2-6 feet but droplets from the mouth containing bacteria are projected upon bedclothes, and however carefully beds are stripped dust will be raised and scattered.

Immediately upon entering the room, the gown, cap and mask are put on. As in any nursing care, the home nurse should have enlisted the help and co-operation of relatives and the supply of hot and cold water, clean linen, etc., should be brought to the sick room by a relative. As pointed out earlier, part of the nurse's responsibility will be to prevent infection occuring in the family group and for this reason the barrier nursing outfit is worn within the confines of the sick room unless it is necessary for the nurse to empty bed-pans and urinals when faeces and urine are potentially infectious.

Special care is needed when stripping or making the bed and in the shaking up of pillows, for every time a blanket is moved bacteria are scattered from it. The risk is less if a bedspread of smooth silky material is used instead of a fluffy fabric. Quite often a relative will help with the making of the bed, particularly if the patient is acutely ill or has tuberculosis and is on complete rest. In this case she, too, wears an overall and mask—the latter being supplied by the nurse and the former can be anything of her own choice and design providing it completely covers her own clothing and is used only when caring for the patient. It should always be kept in the patient's room.

Soiled bed linen and personal clothing are placed in a pail of disinfectant such as Izal, half an ounce to one pail of water, and soaked for 12 hours before being washed. If the laundry is done at home the patient's linen should be washed separately from that of other members of the family, and boiled if possible before being hung out in the fresh air.

Soiled dressings are immediately burnt in the fireplace. During summer months a pail incinerator in the yard or garden can be used for the burning.

When nursing care is completed the mask is removed—care being taken that it is handled only by the tapes, because of the possibility of it having become contaminated with pathogenic organisms. The mask is completely immersed in a jam jar containing Dettol 1:80. As it is not possible to drop the mask into the solution merely by holding the tapes a wooden spatula or clothes peg may be used for this purpose. The masks are left soaking in this until the nurse's visit next day, when they are wrung out and returned to the nurses home in a screw-topped jar or a tin. Masks and container are then placed in the sterilizer and boiled.

The overall and cap are removed and folded outside-in so that contaminated surfaces face each other. They are replaced in the bag which is left immediately inside or outside the room. Finally the hands are washed outside the patient's

room, preferably under running water, before replacing outdoor hat and coat.

Terminal Disinfection

When the patient no longer requires nursing care all the equipment which was taken out is wrapped in a clean piece of stout brown paper and returned to the District Room in the nurses home and dealt with in the following ways:

(*a*) *Washable clothing* is immediately completely immersed in a suitable disinfectant, such as Izal, ½ oz. to one pail of water, and soaked for 12 hours. It is then dried and sent to the laundry for washing.

(*b*) *Boilable articles.* These are boiled for 2-5 minutes.

(*c*) *Unboilable articles*, for example, a thermometer, are soaked in Lysol 1:80 for at least one hour.

(*d*) *Other terminal disinfection.* If it is necessary for the patient's room to be fumigated or the mattress to be stoved, the sanitary inspector deals with this problem. This method is only adopted in domiciliary practice in the severe forms of infection.

Prevention of Droplet Infection

In addition to the precautions which are being taken during nursing care it must be borne in mind that the care of the patient between the nurse's visits, the preparation of his food and the hygiene of the sick-room will be undertaken by a relative. Both patient and family need an understanding of the problem, that is, a knowledge of how the disease is spread, conditions which predispose to infection and the precautions which are necessary in order to avoid infection. Here there is scope for much useful teaching. It is of particular importance when dealing with open cases of tuberculosis. The majority of these patients are acutely aware of the fact that they may contaminate others and they are keen for a knowledge of what and what not to do. It is not difficult to gain their co-operation.

Since droplet infection is the most common way of transmitting tuberculosis infection neither nurse nor relatives should stand in direct line of the patient's breath when caring for him. The patient, on the other hand, can help by turning his head away when speaking; by covering the mouth completely with pieces of old linen or paper handkerchiefs 12 inches square when coughing, and the careful expectoration of sputum. The paper handkerchiefs or pieces of old linen are only used once and are then discarded. They should be placed in a stout paper bag and burned frequently.

Sputum

Sputum should be carefully expectorated into specially designed sputum flasks, sputum mugs or waxed cardboard cartons to which has been added a disinfectant solution. If care is not taken sputum may cling to the sides of the container, become dry and thus a source of infection.

Readers will recall an article in the *Nursing Times* (*A New Method of Sputum Disposal*, January 30, 1954) where it was pointed out how great is the importance of providing an effective bactericide to kill the tubercle bacillus. It was shown then that our use of disinfectants has served to prevent the drying of the sputum but has not in actual fact resulted in the total destruction of the bacilli. For the greatly improved properties of Miltherex as a method of sputum-disposal readers are referred to that article, but as yet this method has not been universally adopted.

Sputum mugs and flasks should be emptied down the W.C. and if the patient is allowed to get up to go to the toilet, he should be responsible for the emptying. The lavatory is flushed and disinfected and the hands washed afterwards. Sputum flasks and mugs are boiled daily for 2-5 minutes in an old saucepan kept exclusively for this. In rural areas when water closets are not provided sputum is carefully emptied in sawdust which is enclosed in several layers of newspaper and the whole is burned.

Disposal of Urine, Faeces and Vomit

If urine, faeces or vomit are infected they should be disinfected before disposal. Izal, 2 oz. to 1 pint, is added to the infected material; the containers are covered with a cloth wrung out in a disinfectant solution, and left to stand as long as possible up to four hours. Infected material is then emptied carefully down the lavatory. Bed-pan, urinal or vomit bowl are then disinfected. A 7-lb. jampot containing disinfectant and a mop are used solely for this.

Generally speaking this aspect of barrier nursing does not come within the scope of the home nurse unless it is before the patient's admission into hospital.

Cleaning of Rooms

It is wiser to leave the cleaning of the room for about one hour after washing and bed-making has been completed so as to allow the dust to settle. Dry sweeping will raise the dust again and increase the bacterial content of the air. The precautions which are necessary will include:

(*a*) *Vacuuming* the floor if possible or mopping it with an oiled cloth kept in a box in the bottom of the patient's cupboard. All dust should be burned.

(*b*) *Damp dusting*, performed by wringing out a duster in disinfectant solution. After carefully dusting all ledges and surfaces the duster is then well washed out in soapy water and hung in the fresh air to dry. It should be boiled at least once a week.

Crockery and Cutlery

Feeding utensils used by the patient should be distinguishable in some way either by colour or shape, and these, too, are kept in a cupboard in the sick-room. Any food which is not eaten by the patient should be burned. The washing up of the feeding utensils is done after the rest of the family washing up is finished. They are first scalded with boiling water, and then washed in the usual way. A separate wiping-up cloth is used for drying and crockery and towel are stored away in the patient's room. The sink and drain are well washed down with running water. Ordinary washing soda, 1 oz. to 1 pint of water, is a suitable disinfectant for sink and drain.

It is frequently necessary to consider occupational therapy for the patient suffering from a long-term illness such as tuberculosis. If the case is infectious one has to bear in mind the possibility of contamination of wool or fabrics such as are used in the making of soft toys, and the need for terminal disinfection of these articles before sale. The personnel at the chest clinic usually deal with this by arrangement with the sanitary inspector. They also often organize a library service for these patients but when this does not exist reading has to be confined to magazines which can be burnt after use.

General Rules of Prevention

One of the home nurse's main responsibilities is the maintenance of good health—both her own and that of the family, for it is not so much the fact of being in contact with infection which determines whether a person becomes a prey to it, but rather the state of health at the time of contact. It is wise to plan the time when the nursing care is given so that it is not when the nurse is tired and hungry. In addition to this she will need to give help and advice to the family. It is useless to teach the value of a balanced diet and the importance of certain food-stuffs if there is a lack of money to buy them. By her observation of the family habits she may also be able to advise on better modes of hygiene and standards of living, such as adequate rest and ventilation.

In spite of educational efforts there still hangs around tuberculosis an aura of fear which the home nurse will need to bear in mind when dealing with the families of patients. Tuberculosis is more often contracted during the years when good health is the expected state and the responsibilities of life are the greatest. The illness comes as a heavy blow and is usually accompanied by emotional stress and the patient therefore needs the support, understanding and care of the family more than when he was in good health. Rigid isolation should at all costs be avoided and although it is necessary for nursing equipment and feeding utensils to be kept within the patient's room, it is equally important for them to be stored away, so that the patient is not being continually reminded that he is ill and probably will remain incapacitated for some considerable time. The home nurse, though only one of a team who is working towards the patient's recovery, has a great part to play in ensuring that the patient is restored to his family, his work and the community physically fit and psychologically adjusted.

Industrial Ophthalmology in a Medical Treatment Centre*

by R. H. P. FERNANDEZ, M.B., Ch.B., O. P. EDMONDS, M.B., Ch.B., and T. A. HUNT, M.B., Ch.B., M.Sc.; Area Medical Officers, National Coal Board, East Midland Division.

IN our experience, the majority of nurses in industrial medical centres not under constant medical supervision have not the same degree of confidence in dealing with eye cases as they have with the usual traumatic industrial patients. In these medical centres the treatment has to be limited by the views of the general practitioner whose patient the nurse is treating. Hence treatments of specific eye conditions have been excluded from this lecture. Providing this is realized and if the nurse always carries out the same type of routine examination, she should not get herself into difficulties.

Vision

The function of our eyes is to see the environment around us, thus it is essential always to test and record the visual acuity of every eye patient. This should be tested even before the history is elicited or an examination performed as, in our experience, it is liable to be forgotten. However, if there is any history of liquid splashing into the eye then the eye should immediately have this liquid washed out and it is in these emergency cases that the vision is not recorded first.

The distant visual acuity is a better guide than the reading visual acuity because of the need for reading glasses in middle age.

The Snellen's test type is used; it must be kept clean and have its own illumination. The ordinary Snellen's test type kept in a surgery for six months and illuminated by ordinary sunlight can vary as much as one line in the reading elicited from a patient with defective visual acuity as compared with a clean test type with its own illumination.

The patient should be seated six metres (19 ft. 8 in.) away from the card and this distance should be accurately measured and not paced. The test type is positioned at eye level. In small surgeries, a mirror three metres away from a chart with reversed letters, the latter being placed above the patient's head, is used. We prefer the patient to be seated as it is easier to occlude each eye and care must be taken to see that each eye is fully occluded when the vision of the other is tested. The most efficient way of occlusion is to use a trial frame and a blank disc. The seated patient relaxes and concentrates more than the standing one, especially when the eyes are injured. The right eye is tested first and then the left, the record being made in the same manner, for example, right = 6/6, left = 6/6. The top '6' infers that the patient is situated six metres from the chart; the bottom ' 6 ' that he is seeing the letters which a normal person sees six metres away. Hence, the vision 6/36 means that the patient sees at six metres the letters which a normal person can see at 36 metres. The visual acuity is the smallest lettered line which the patient gets completely correct. If a patient makes one mistake on a line it should be recorded, for example, 6/6-1. The reading of the Snellen's test type from the 6/60 line downwards in every eye case can cause the patient to memorize the chart and waste the nurse's time. A prominent red line should be drawn under the 6/12 line and the patient told to read those letters he can see under it. If a doctor is confident that the nurse always records the visual acuity in the same manner and under standard conditions, it becomes a valuable index of the eyes' efficiency, but when it is performed in a haphazard manner it has little value. We have seen visions recorded as 6/9 when really the complete line which was read correctly was 6/18.

Unilateral or bilateral deterioration of vision of more than one line in any age group with no apparent cause should always be referred to a doctor. Teenagers can have normal vision when they enter industry yet within two years because of simple short-sightedness may have that vision lowered to 6/60, and without glasses are a danger to themselves and others. Certain diseases, for example cataracts, optic atrophy and glaucoma, cause deterioration of vision and in the retrobulbar neuritis of disseminated sclerosis, the vision, usually of one eye, may deteriorate from normal to 6/60 and back to normal again in two months. Here the vision is a valuable sign and is often missed

If one eye is to be padded because of treatment and the vision of the other is less than 6/36, the patient not having glasses which improve this vision, then it is unsafe for the patient to continue working and he should be escorted home. Similarly, only the most competent person should treat an eye where these circumstances exist and where there is a danger of the sight in the good eye being impaired, for example when there is a central foreign body on the cornea.

Those with optical errors causing defective acuity will see the 6/6 line if viewed through a hole 1 mm. in diameter in a piece of cardboard placed over the eye. This is called the Pin-Hole Disc Test. Once the visual acuity is tested and recorded the nurse should then obtain the patient's history.

History

Most patients with conjunctivitis state that they have something in their eye and the nurse should always attempt to find out when the patient thought this happened. Usually no foreign body is found when the answer is vague. Patients with conjunctivitis often state that the lids are gummed together in the morning after a night's sleep. One of the major worries in industry is the foreign body which penetrates inside the eye and the history often points to this, the patient feeling something fly into his eye when he was hitting or chiselling an object which was brittle. With this history care must always be taken to exclude an intra-ocular foreign body. Arc welding or ultra-violet light in which the goggles have not been efficient or have been taken off may cause the eye to become red, painful and watery; this occurs four to five hours after exposure. It usually affects both eyes and, of course, affects bystanders.

Any patient who complains of headache together with pain in the eye should be referred to a doctor as it is a prominent symptom in increased intra-ocular pressure. Similarly, the case must be referred if the eye symptoms have been present for over a week. Any change in the field of vision—for example, only being able to see half an object when looking with one eye open—should also be referred.

Black specks seen floating downwards when the patient looks upwards in bright sunlight is not abnormal but black spots which are stationary in any position or coloured flashes of light require a doctor's advice. Halos seen around an electric light after dark may be a pointer towards glaucoma.

Examination

The patient is seated and with the aid of a good light the eyes are examined. The lids should be inspected and note made that there is no skin irritation, stye (a pustule surrounding a hair follicle on the lid margin) or meibomian cyst (lump in the lid). This latter may be inflamed and the lid swollen

* *Abstract of a lecture delivered at the Royal College of Nursing Occupational Health Section East Midland Area Conference.*

because of a localized cellulitis. Boracic fomentations are often used to bathe an inflamed eye but some skins are sensitive to boracic and the irritation which occurs looks like a cellulitis around the orbit. The temperature, however, is not raised and the patient not ill. In our experience, boracic irritation is far commoner than cellulitis of the orbit and we never advocate bathing with boracic as a routine procedure because of this.

In some industrial centres first-aid personnel cover certain hours of the day and while they obviously do not treat eyes, they are often taught to remove foreign bodies with the aid of cotton wool. It is essential that such staff should have their finger nails checked regularly to see that they are kept short as a nail can easily scratch the cornea when the eyelids are being everted.

Once the lids have been inspected the rest of the eye should be examined with the aid of a good light, note being taken that the sclera is white and that there are no injected veins in the conjunctiva which covers the sclera.

In a penetrating wound of the eye sometimes a small black mark is seen where the foreign body has gone into the eye. This is, however, not a constant finding. It is invariably situated on the outer side of the eye which has not the same degree of protection as the inner side because of the nose and orbit. Some patients believe that lotions and eye-drops should be used regularly to help the efficiency of the ocular mechanism. If silver drops are used for many months they can lead to argyrosis of the conjunctiva, causing it to lose its translucency and take on a brownish appearance. This is most difficult to treat and it should be stressed to all patients that they should never use any preparation constantly to the eye unless it is under medical advice.

Between the sclera and conjunctiva in an otherwise normal eye the patient may have a small clot of blood (sub-conjunctival haemorrhage). Often this is due to severe blowing of the nose but can be seen in cases with hypertension. Unless the blood clot is under most of the conjunctiva it requires no treatment, but a doctor should see it and reassure the patient.

Excessive watering of the eye over weeks may be caused by a blockage in the tear-duct and the patient should be referred to a doctor. This condition is disturbing and drops are of little help.

The Cornea

The cornea, the clear window of the eye, should next be examined with the aid of magnification, for example, a binocular loupe. If it looks cloudy instead of clear the case should be referred. Foreign bodies in the cornea can often be easily seen but a foreign body may have damaged the cornea and then been removed by blinking, leaving an abrasion on the cornea. Where no foreign body is found a drop of 2 per cent. fluorescein should be instilled in the eye and after a few seconds washed out with normal saline, any abrasion of the cornea being revealed by a green stain.

When a patient is having drops instilled in the eye the head should be tilted backwards and slightly towards the other eye and the lids should be gently kept open with the help of the fingers. The drops should be allowed to flow across the inner side of the eye in the lower fornix as it is discomforting and painful when they are dropped on the cornea, making the patient blink and dispersing the liquid over the face. This is a very common mistake and we believe that when drops are applied the patient should be told exactly what is happening.

If the cornea is free from disturbance the coloured part of the eye, the iris, should be examined. In between the iris and the cornea is the anterior chamber and pus or blood may collect here. These cases must be referred to a doctor.

Patients with eye disorders often have at home Golden Eye Ointment which they immediately apply. Unfortunately, 1 per cent. atropine ointment looks exactly the same and when applied leaves the pupil large and immobile to light. The distant vision is impaired and reading impossible. The patient will have these symptoms for over a week and if both eyes are affected cannot do close work. They usually will not admit to having used the ointment at home.

When foreign bodies are suspected under the lids the upper lid should always be examined first as manipulation of this lid may cause a foreign body to fall down behind the lower lid. Eversion of the upper lid is best performed by using a thin rod held horizontally along the skin of the upper lid with the patient looking down towards his feet. The eyelashes should be held between the left index finger and the thumb and the lid pulled away from the eye. It is then rotated around the rod. Many nurses trained in eye departments evert lids efficiently with the aid of their fingers but if this method is used it must be performed gently. After the upper lid has been inspected the lower one should be pulled away from the eye and any foreign body in the lower fornix of the conjunctiva looked for. Remember, fine particles of quartz are difficult to see because of their translucency.

Treatments

Small, ingrowing eyelashes cause irritation to the eye, especially on the inner side near the punctum, and these should be removed with the aid of epilation forceps.

Foreign bodies under the lids are best removed with moist cotton wool wrapped round a wooden applicator (orange stick).

Foreign bodies of the cornea which are resistant to removal by the wooden applicator should be removed with the aid of a metal spud which has first been sterilized in a flame and after the eye has been anaesthetized with 1 per cent. pantocaine. The hand holding the spud should rest lightly on the forehead to prevent tremor and the lids are held open with the fingers of the other hand. These should be pressed slightly backwards to steady the globe. Obviously, this operation should be done under illumination.

If acids have been splashed into the eye they should be washed out with weak alkalies, for example, 3 per cent. sodium bicarbonate lotion. Alkalies similarly should be washed out with weak acid solution, for example, 2 per cent. boracic acid lotion; but we are great believers in generous quantities of ordinary saline as a washing-out medium to any eye case which has been splashed, as the appropriate antidote is often not available in sufficient quantities. Putting the head in a bucket of water has saved the eyesight of many where the eyes have been splashed with corrosive substances.

Lime burns are extremely serious as until every particle is removed from the eye it will continue to burn and damage the cornea and conjunctiva. Any particles in the eye should be removed with forceps after irrigation and after instillation of 1 per cent. pantocaine. The eye should then be washed out with 10 per cent. neutral ammonium tartrate which diminishes the scarring in lime burning. Obviously all these cases should be referred to an eye department after the appropriate first-aid treatment.

The eye is only padded when the cornea is damaged or if the conjunctiva has been rendered insensitive by a local anaesthetic. When the latter occurs foreign bodies can enter the eye without the patient knowing. If adhesives are used to retain the pad, inquiry should be made whether the patient's skin is irritated by them.

Any eye that is inflamed—for example, by conjunctivitis or a foreign body—greatly benefits from the application of moist heat. A pad of cotton wool is tied into the bowl of a wooden spoon and the wool is dipped into a bowl of boiling water and brought as close as the patient can bear to the closed, affected eye. As soon as it has cooled the procedure is repeated and the patient does this for 10-15 minutes. While this procedure can be repeated at frequent intervals, it does cause the skin to become soggy and we therefore limit this treatment—which is an excellent one—to three times a day.

Clear Labelling

It must be stressed that eye-drops and ointments should be clearly labelled as to what they contain and must never be applied to the eye unless the nurse has examined the label. Ointments are very useful to place in the patient's eye at night, especially in conjunctivitis where they prevent the lids sticking together. Usually in medical treatment centres sulphacetamide drops are used as an antibiotic and in the mines first-aiders on the actual coal face possess these drops

and this practice, which has been going on for many years, has caused a marked reduction in the severity of eye injuries. These drops should always be used three-hourly in any eye which is infected or in any danger of being infected.

Whilst 5 per cent. cocaine or its lamellae has been a standard method of anaesthetizing the conjunctiva and cornea, 1 per cent. pantocaine is probably preferable as it is stated[1] that it does not damage the corneal epithelium or dilate the pupil, nor has it the idiosyncriatic side reactions of cocaine. The best washing-out medium for the eye is normal saline.

If a nurse takes an active interest in ophthalmic conditions, she will find it a fascinating study and her experience and confidence will grow.

[We would like to thank Dr. J. Trefor Watkins, our divisional medical officer, for all his valuable guidance.]

REFERENCE

[1] Parsons' Diseases of the Eye, 12th edition, page 392.

London Nursing Exhibition, October 11-15, 1954

READERS of the NURSING TIMES are invited to visit Stand B1 at the 39th Annual HOSPITALS, NURSING, MIDWIFERY AND PUBLIC HEALTH EXHIBITION AND CONFERENCE, to be held under the auspices of the NURSING MIRROR, at Seymour Hall, Seymour Place, W.1. Lectures to be given during the exhibition are listed below, and special features, professional film sessions, and a list of exhibitors will be found on the next page.

Monday, October 11

Opening Day

11.15 a.m. The Blackham Memorial Lecture—A HUNDRED YEARS AGO by Arthur A. Gemmell, Esq., M.C., T.D., M.D., F.R.C.S.E., President, Royal College of Obstetricians and Gynaecologists. *Chairman*: Sir Russell Brain, Bt., D.M., President, Royal College of Physicians.

12.30 p.m. OFFICIAL OPENING by Lady Churchill, G.B.E.

2.45 p.m. THE PREVENTION AND TREATMENT OF COMPLICATIONS FOLLOWING HYSTERECTOMY, by Victor Lack, Esq., F.R.C.P., F.R.C.O.G., Obstetric and Gynaecological Surgeon, London Hospital. *Chairman*: R. Christie Brown, Esq., M.S., F.R.C.S., F.R.C.O.G., Surgeon, Samaritan Hospital for Women; Obstetric Surgeon, City of London Hospital.

4.30 p.m. THE ACTIVITY OF UTERINE MUSCLE: Professor W. I. C. Morris, F.R.C.O.G., Professor of Obstetrics and Gynaecology, University of Manchester. *Chairman*: Clifford White, Esq., M.D., F.R.C.P., F.R.C.S., F.R.C.O.G. Consulting Obstetric Surgeon, University College Hospital.

Tuesday, October 12

Recent Advances in Surgical and Medical Problems

10.30 a.m. BURNS AND SCALDS by Rainsford Mowlem, Esq., F.R.C.S., Surgeon-in-Charge, Plastic Department, The Middlesex Hospital. *Chairman*: Sir Cecil Wakeley, Bt., K.B.E., C.B., P-P.R.C.S., Senior Surgeon, King's College Hospital.

11.45 a.m. MALIGNANT DISEASE OF THE LUNG AND ITS NURSING CARE by Sir Clement Price Thomas, K.C.V.O., LL.D., F.R.C.S., Surgeon, Westminster Hospital and Brompton Hospital. *Chairman*: Sir Stanford Cade, K.B.E., C.B., F.R.C.S., Senior Surgeon, Westminster Hospital.

2.15 p.m. THE PRE- AND POSTOPERATIVE CARE OF THE ANAESTHETISED PATIENT by Dr. A. H. Galley, M.B., B.S., F.F.A.R.C.S., D.A., Anaesthetist, King's College Hospital. *Chairman*: A. D. Marston, Esq., C.B.E., F.R.C.S., F.F.A.R.C.S., D.A., Director, Department of Anaesthetics, Guy's Hospital.

3.30 p.m. THE NURSING CARE OF THE INCURABLE PATIENT by Dr. Marjory Warren, M.R.C.S., L.R.C.P., Consultant Physician, Geriatric Unit, and Deputy Medical Director, West Middlesex Hospital. *Chairman*: The Rt. Hon. The Lord Amulree, M.D., F.R.C.P., Physician, University College Hospital.

4.45 p.m. HIGH BLOOD PRESSURE AND ITS TREATMENT by Dr. A. G. Leatham, M.R.C.P., Assistant Director, Institute of Cardiology, National Heart Hospital. *Chairman*: Sir Harold Boldero, M.A., D.M., F.R.C.P., Physician, Middlesex Hospital; Dean of the Medical School, Middlesex Hospital.

Wednesday, October 13

Recent Advances in Medical and Surgical Problems

10.30 a.m. ARTHRITIS OF THE HIP by Professor Walter Mercer, F.R.S.Ed., F.R.C.S.Ed., Professor of Orthopaedic Surgery, University of Edinburgh. *Chairman*: Sir Reginald Watson-Jones, M.Ch.Orth., F.R.C.S., Orthopaedic Surgeon to Her Majesty Queen Elizabeth II.

11.45 a.m. THE HAZARDS OF BLOOD TRANSFUSION by Dr. R. A. Zeitlin, M.R.C.S., L.R.C.P., Medical Director, South London Blood Transfusion Centre. *Chairman*: Sir John Charles, M.D., F.R.C.P., Chief Medical Officer, Ministry of Health.

2.15 p.m. THE CONJOINED TWINS OF KANO: film with commentary by Selwyn Taylor, Esq., M.Ch., F.R.C.S., Surgeon, King's College Hospital. *Chairman*: Sir William Gilliatt, K.C.V.O., M.D., M.S., F.R.C.P., F.R.C.S., F.R.C.O.G., Surgeon-Gynaecologist to Her Majesty Queen Elizabeth II.

3.30 p.m. THE PRE- AND POSTOPERATIVE CARE OF INTUSSUSCEPTION IN INFANTS by G. H. Macnab, Esq., F.R.C.S., Surgeon, Westminster Hospital, The Hospital for Sick Children, Great Ormond Street, and Westminster Children's Hospital. *Chairman*: Edward G. Slesinger, Esq., O.B.E., M.S., F.R.C.S., Emeritus Consulting Surgeon, Guy's Hospital.

4.45 p.m. TUBERCULOSIS AND OTHER DEFORMITIES OF THE SPINE IN CHILDREN by Robert Roaf, Esq., M.Ch.Orth., F.R.C.S., Orthopaedic Surgeon, Royal Liverpool United Hospital. *Chairman*: Professor H. J. Seddon, C.M.G., M.A., D.M., F.R.C.S., Clinical Director, Royal National Orthopaedic Hospital; Director, Institute of Orthopaedics.

6.30 p.m. PSYCHIATRY FROM THE NURSING POINT OF VIEW by Dr. E. Stengel, M.D., M.R.C.P., Reader in Psychiatry, University of London; Hon. Consulting Physician, Bethlem Royal and Maudsley Hospitals. *Chairman*: Dr. Desmond O'Neill, M.C., M.D., M.R.C.P., Physician, Department of Psychiatry, St. Mary's Hospital.

Thursday, October 14

Obstetrics and Gynaecology from the Nursing Point of View

10.30 a.m. HAS THE CONSERVATIVE TREATMENT OF PLACENTA PRAEVIA BEEN JUSTIFIED by Professor C. H. G. Macafee, F.R.C.S.I., F.R.C.S.Eng., F.R.C.O.G., Professor of Midwifery and Gynaecology, Queen's University of Belfast. *Chairman*: V. B Green-Armytage, Esq., M.D., F.R.C.P., F.R.C.S., F.R.C.O.G., Consulting Gynaecologist, West London Hospital.

11.45 a.m. THE PREVENTION AND CONTROL OF STAPHYLOCOCCUS IN A MATERNITY UNIT by J. B. Blaikley, Esq., F.R.C.S., F.R.C.O.G., Obstetric Surgeon and Director of the Department of Obstetrics and Gynaecology, Guy's Hospital. *Chairman*: A. J. McNair, Esq., M.A., F.R.C.S., F.R.C.O.G., Emeritus Consulting Obstetric Surgeon, Guy's Hospital.

2.15 p.m. THE IMPORTANCE OF DOMICILIARY MIDWIFERY IN A NATIONAL MATERNITY SERVICE by Hector MacLennan, Esq., M.D., F.R.F.P.S., F.R.C.O.G., Senior Consulting Gynaecologist, Victoria Infirmary, Glasgow. *Chairman*: Rufus C. Thomas, Esq., F.R.C.S.Ed., F.R.C.O.G., Consulting Obstetrician and Gynaecologist, Kent County Council

3.30 p.m. URINARY SYMPTOMS IN OBSTETRICS AND GYNAECOLOGY by Professor A. S. Duncan, D.S.C., F.R.C.S., F.R.C.O.G., Professor of Obstetrics and Gynaecology, Welsh National School of Medicine. *Chairman*: Professor J. C. McClure Browne, F.R.C.S., M.R.C.O.G., Professor of Obstetrics and Gynaecology, University of London.

4.45 p.m. MANAGEMENT OF THE THIRD STAGE OF LABOUR by J. D. S. Flew, Esq., M.D., F.R.C.O.G., Assistant Obstetric and

Professional Film Sessions

Monday, October 11

1 p.m. (A) Cardiovascular Pressure Pulses.
(B) The Technique of Bandaging with Tubegauz.
(C) Morphological Changes of B. Coli under the Influence of Anti-Bacterial Substances.
6 p.m. (D) PAS (Chemotherapy of Tuberculosis with p-aminosalicylic acid).

Tuesday, October 12

1 p.m. (C) Diagnosis and Treatment of Phaeochromocytoma.
(E) Simple Nutrition.
(A) Therapy Influencing the Autonomic Nervous System.
6 p.m. (F) Extraperiosteal Pneumonolysis with the Polystan Plombe.

Wednesday, October 13

1 p.m. (G) The General Practitioner and Rheumatic Disease.

Thursday, October 14

1 p.m. (H) The British Midwife.
(I) Relief of Pain in Childbirth.
(J) Caesarean Section.
6 p.m. (A) Electrokymography, Venous Catheterization and Angiocardiography.
(K) Urine Analysis for Diabetics.

Friday, October 15

1 p.m. (G) Diseases of the Ear, Nose and Throat.
(F) The Sprained Ankle—Its Treatment by rest and Support.

(A) G. D. Searle and Co. Ltd., 17, Manchester Street, W.1. (B) The Scholl Manufacturing Co. Ltd., 182-204, St. John Street, E.C.1. (C) Ciba Laboratories Ltd., Horsham, Sussex. (D) A. Wander Ltd., 42, Upper Grosvenor Street, W.1. (E) The Marmite Food Extract Co. Ltd., Walsingham House, Seething Lane, E.C.3. (F) Smith and Nephew Ltd., Tewin Road, Welwyn Garden City, Herts. (G) John Wyeth and Brother Ltd., Clifton House, Euston Road, N.W.1. (H) The Royal College of Midwives, 57, Lower Belgrave Street, S.W.1. (I) I.C.I. Film Library, Imperial Chemical House, Millbank, S.W.1. (J) Reckitt and Colman Ltd., Dansom Lane, Hull. (K) Mitre Laboratories Ltd., 58, Albany Street, N.W.1.

Gynaecological Surgeon, University College Hospital. *Chairman*: Leslie Williams, Esq., M.D., M.S., F.R.C.S., F.R.C.O.G., Senior Obstetric Surgeon, Inpatients, St. Mary's Hospital.

Friday, October 15

New Methods of Diagnosis and Treatment

10.30 a.m. OFFICIAL VISIT OF H.R.H. Princess Alice, Countess of Athlone, V.A., G.C.V.O., G.B.E., G.C.St.J.

10.30 a.m. THE CONJOINED TWINS OF KANO: film with commentary by Professor Ian Aird, Ch.M., F.R.C.S., Professor of Surgery, University of London; Director, Surgical Unit, Postgraduate Medical School of London. *Chairman*: Sir Cecil Wakeley, Bt., K.B.E., C.B., P-P.R.C.S., Senior Surgeon, King's College Hospital.

11.45 a.m THE TREATMENT OF ADVANCED MALIGNANT DISEASE AND RADIOTHERAPY by Professor B. W. Windeyer, F.R.C.S., F.F.R., Director, Meyerstein Institute of Radiotherapy, The Middlesex Hospital. *Chairman*: the Rt. Hon. The Lord Horder, G.C.V.O., M.D., F.R.C.P., Consulting Physician, St. Bartholomew's Hospital.

2.15 p.m. ARTERIAL GRAFTING by Professor C. G. Rob, M.C., M.A., F.R.C.S., Professor and Examiner in Surgery, University of London; Surgeon, St. Mary's Hospital. *Chairman*: Sir James Paterson Ross, K.C.V.O., M.S., F.R.C.S., Surgeon to Her Majesty Queen Elizabeth II; Professor of Surgery, University of London; Surgeon and Director, Surgical Clinical Unit, St. Bartholomew's Hospital.

3.30 p.m. HYPNOTICS AND THEIR USES AND ABUSES, by Dr. F. P. Lee Lander, O.B.E., M.D., F.R.C.P., Physician, Royal Free Hospital and Brompton Hospital. *Chairman*: Dr. Helen Dimsdale, M.A., M.D., F.R.C.P., Neurologist, Royal Free Hospital.

4.45 p.m. DIABETES by Dr. Wilfrid Oakley, M.A., M.D., F.R.C.P., Physician, and Physician Diabetic Department, King's College Hospital. *Chairman*: Dr. E. F. Scowen, M.D., F.R.C.P., Physician, St. Bartholomew's Hospital.

* Special Features *

FLORENCE NIGHTINGALE: BEFORE and AFTER

This month marks the centenary of the mission to the Crimea of Florence Nightingale who has long been accepted as the founder of modern nursing. The centrepiece of the stage display of pictures this year, therefore, takes the form of a full length silhouette of Miss Nightingale, standing as it were in the doorway between old and new. On the left of her are scenes illustrating nursing from earliest times to the 19th century: on the right the various developments of modern nursing that have stemmed from Florence Nightingale's work and teachings.

*

MODERN MATERNITY

The exhibit staged by the British Electrical Development Association is subdivided into four sections covering the needs of nurses in hospital and nursing home maternity work, nurses and health visitors at clinics, and midwifery in the patients' homes. The fourth section deals with the nurse's personal needs in her own quarters or home.

Exhibitors at the London Nursing Exhibition

(listed in order of stands)

A. Faber and Faber Ltd.
B1. *NURSING TIMES.*
B2. E. J. Frankland and Co. Ltd.
B3. H. J. Heinz Co. Ltd.
B4, J. and H. Walter Ltd.
B5, Oxygenaire (London) Ltd.
B6, Scholl Manufacturing Co. Ltd.
B7, Clinical Products Ltd.
B8. Marmite Food Extract Co. Ltd.
B9. Norgine Pharmaceutical Products (London) Ltd.
C. Norwich Union Insurance Societies.
D1, 2, 3. Crookes Laboratories Ltd.
D4. Reckitt and Colman Ltd.
E1, 2. Macleans Ltd.
E3. W. J. Rendell Ltd.
E4. Chilprufe Ltd.
E5. S. H. Camp and Co. Ltd.
E6. Milton Antiseptic Ltd.
F1. Baillière, Tindall and Cox Ltd.
F2. Jeyes' Sanitary Compounds Co. Ltd.
F3, 6. Tampax Ltd.
F4, 5. Lactagol Ltd.
G1. Smith and Nephew Ltd.
G2, 4. William R. Warner Ltd.
G3. Cow and Gate Ltd.
H1, 2. North Thames Gas Board.
I1, 3. Cadbury Bros. Ltd.
I2, 4. Nestle Co. Ltd.
J1. Don. S. Momand Ltd.
J2, 3. International Chemical Co. Ltd.
J4. Bovril Ltd.
J5. Paines and Byrne Ltd.
J6. Continental Laboratories Ltd.
K1, 4. John Wyeth and Brother Ltd.
K2. British Schering Ltd.
K3. Energen Foods Co. Ltd.
K5. Brand and Co. Ltd.
K6. A. Wander Ltd.
L1. W. H. Bailey and Son Ltd.
L2. Wright Layman and Umney Ltd.
L3. Swacot Products.
L4. Boyd-Cooper Ltd.
M. Rozalex Ltd.
N. H. K. Lewis and Co. Ltd.
O1. Genatosan Ltd.
O2. Royal National Pension Fund for Nurses.
P1. Riddell Products Ltd.
P2. John Bell and Croyden.
Q1. Ciba Laboratories Ltd.
Q2. Weetabix Ltd.
R1, 2. Keen, Robinson and Co. Ltd.
S1, 2. British Electrical Development Association.
S3. Educational and Scientific Plastics Ltd.
S4. Federated Superannuation Scheme for Nurses.
Foyer Martyns Hospital Hairdressing Service.

Recent Advances in the Investigation and Treatment of Heart Disease*

by AUBREY LEATHAM, B.A., M.R.C.P., Physician, St. George's Hospital; Assistant Director, Institute of Cardiology, National Heart Hospital.

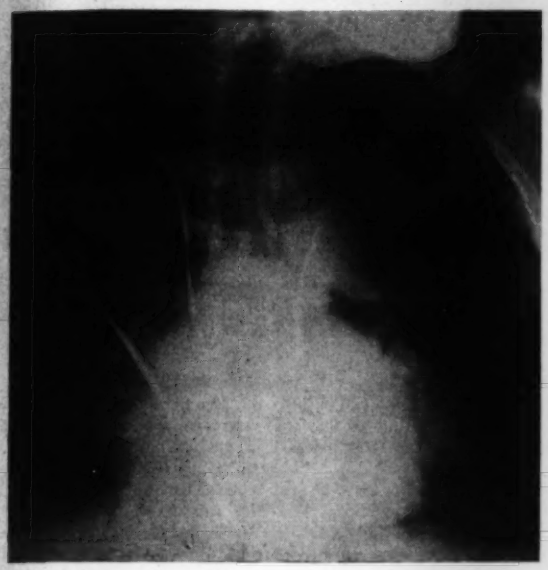


Fig. 1. *Normal course of catheter passing down superior vena cava into right auricle, across through the tricuspid valve into right ventricle, and up into pulmonary artery. Some radio-opaque solution has been injected through the catheter to outline the pulmonary artery. The shadow on the left crossing the cardiac outline is a lead to the electrocardiograph which is used throughout the investigation in order to detect any change in cardiac rhythm.*

CARDIAC CATHETERIZATION

Fig. 2. *Atrial septal defect. The catheter has passed from the right auricle, through the interatrial septal defect into the left auricle, and into a pulmonary vein.*

ADVANCES in surgical technique resulting in alleviation of the effects of rheumatic and congenital heart disease have stimulated the need for more accurate methods of diagnosis. A brief sketch will be given of the methods of cardiac catheterization, angiocardiography, and phonocardiography.

A cardiac catheter is a slender, flexible nylon tube about 40 inches long. Under local anaesthesia, with the patient lying comfortably on an X-ray couch, the catheter is introduced into a superficial vein of the forearm. A sedative is usually given beforehand to allay apprehension, and with good technique the method is entirely devoid of pain. The catheter passes up a forearm vein into a deep neck vein and is then guided down into the superior vena cava and right auricle by means of visualization of the catheter on the X-ray screen. The nylon tubing has been given a slight curl, and by means of rotation can be manipulated through the tricuspid valve into the right ventricle and pulmonary artery (Fig. 1).

This method of cardiac catheterization was originally introduced in order to obtain a sample of blood from the pulmonary artery as part of the information required to calculate the amount of blood pumped by the heart—the cardiac output. This use is mainly for research purposes but may have great practical application in the future, especially when estimations of the maximal output of the heart during exertion can be easily obtained.

During routine diagnostic cardiac catheterization, samples of venous blood are taken from the pulmonary artery, right ventricle, right auricle and superior vena cava, and are normally approximately the same and about 70 per cent. saturated with oxygen. In congenital heart disease there may be a flow of blood (shunt) from the aorta into the pulmonary artery through a patent ductus arteriosus, and this will result in abnormally high oxygen saturation of blood obtained from the pulmonary artery compared with samples from the right ventricle, right auricle, and superior vena cava. In ventricular septal defect, with a shunt of oxygenated blood from the left ventricle into the right ventricle, the abnormally high oxygen saturation will be found in the right ventricle. In atrial septal defect, with a shunt of oxygenated blood from the left auricle into the right auricle, an abnormally high oxygen saturation will be found in the right auricle compared with the superior vena cava. In this way, left-to-right shunts from congenital heart disease can be diagnosed with great accuracy and the proportion of blood which is being shunted can even be calculated.

The course taken by the catheter can also be used for diagnostic purposes. The catheter may be seen on the X-ray to pass from the right auricle through an atrial septal defect into the left auricle (Fig. 2), or it may have passed from the right ventricle into the aorta placed over the right ventricle as in Fallot's tetralogy. It may pass from the main pulmonary artery into the aorta through a patent ductus arteriosus.

Finally, a cardiac catheter is used for the measurement of intra-cardiac pressures. The pressure pulse from each

* *Based on a lecture given during a special course for ward sisters at the Royal College of Nursing.*

Fig. 3. *Cardiac catheterization. The patient is lying on an X-ray couch with a viewing screen above the chest. The forearm has been cleaned and placed on sterile towels and a suitable antecubital vein has been selected. The instruments for exposing the vein are shown on the trolley and a cardiac catheter is coiled in the nearest bowl. The next apparatus is a spirometer for measuring oxygen consumption, then a cathode ray tube for visualizing the electrocardiogram and the pressure pulse, and finally the multichannel recorder and electrical manometer.*

cardiac chamber is transmitted down the catheter and transformed into waves of electrical energy by means of an electrical manometer. These electrical changes are amplified and recorded on a multi-channel electrical recorder. The pressure pulses can also be visualized at the time of the investigation on a cathode ray tube. In the same way, the electrocardiogram may be visualized on the cathode ray tube and is therefore useful for detecting any arrhythmia which may take place during the investigation. The apparatus required for pressure pulse recording is shown in Fig. 3. Normally, the pressures in the pulmonary artery and right ventricle measure about 20/10 and 20/0 mm. Hg. respectively, much less than on the left side. In pulmonary hypertension the systolic pressure in the pulmonary artery and right ventricle may rise to 120 mm. Hg. or more. In pulmonary stenosis the systolic pressure in the right ventricle may rise to 300 mm. Hg., while pressure in the pulmonary artery is abnormally low.

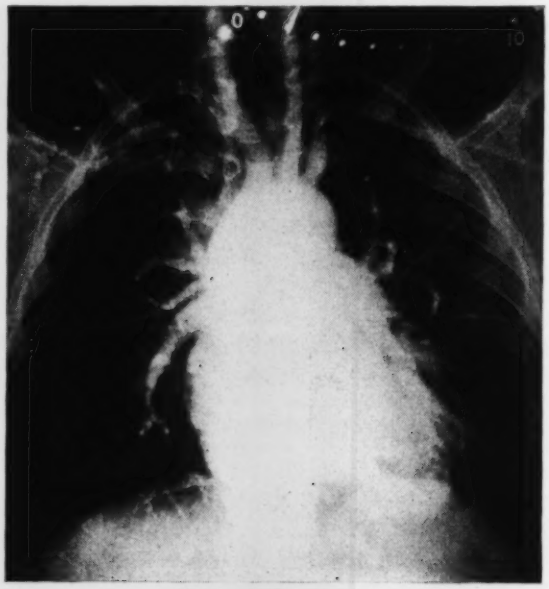
In mitral stenosis the pressure proximal to the obstruction is raised and it is obviously a great diagnostic help if the pressure in the left auricle can be measured. This can be done by pushing a cardiac catheter into a small branch of the main pulmonary artery until it blocks a very fine branch obstructing the onward flow of blood from the pulmonary artery. The pressure from the left auricle is then transmitted backwards through the pulmonary veins and pulmonary capillary to the tip of the catheter. Further information can be obtained from the contours of the pressure pulses.

Angiocardiography

Angiocardiography consists of the rapid injection of a radio-opaque solution into a vein in the forearm. This solution rapidly reaches the right auricle and passes through the various chambers of the heart. In the meantime, X-ray films are taken in quick succession demonstrating the shape of the various vessels and chambers and any abnormal order of filling of the vessels or chambers (Fig. 4). A general anaesthetic or injection of morphine is usually given since the radio-opaque material causes uncomfortable sensations.

ANGIOCARDIOGRAPHY

Fig. 4. *Angiocardiogram in a case of Fallot's tetralogy. The radio-opaque material fills the right auricle, right ventricle, pulmonary artery and main branches. Simultaneously, and quite abnormally, the aorta, carotid and subclavian arteries have been filled with the radio-opaque material before it has returned from the lungs to the left side of the heart, indicating a direct communication between the right ventricle and over-riding aorta.*



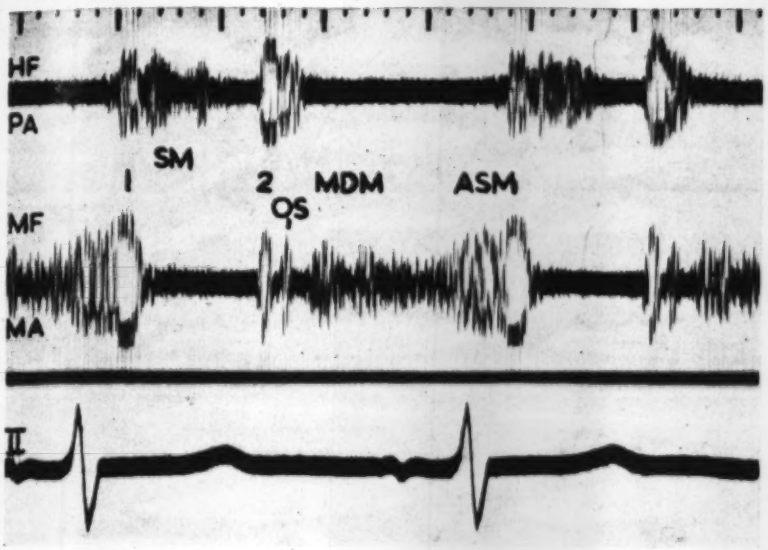
Phonocardiography

Phonocardiography is the technique of recording heart sounds and murmurs by means of microphones placed over the heart (Fig. 5). The electrical impulses produced by these sounds and murmurs are amplified and recorded on photographic film or paper (Fig. 6 and 7). Much information can be obtained by seeing the relationship of the heart sounds and murmurs to each other on the photographic recording.

Surgical Treatment

Surgical treatment of rheumatic and congenital heart disease has made remarkable advances in recent years and is expected to produce even more dramatic results in the future with the aid of refrigeration and the artificial heart, so that the surgeon can spend more time on the particular surgical repair in the heart or great vessels. In Fallot's tetralogy (pulmonary stenosis with aorta over-riding the right ventricle) the Blalock operation was devised to increase the flow of blood to the lungs by an indirect method. A branch of the aorta was anastomosed to the pulmonary artery, thus by-passing the obstructed pulmonary valve or outflow tract.

Mr. R. C. Brock later



PHONOCARDIOGRAPHY

Fig. 6. *Phonocardiogram recorded from a patient with mitral stenosis showing diastolic murmurs following the second heart sound (2) in the middle tracing. This patient was much improved by mitral valvotomy.*

way, an operation for the relief of aortic valve stenosis is now being performed.

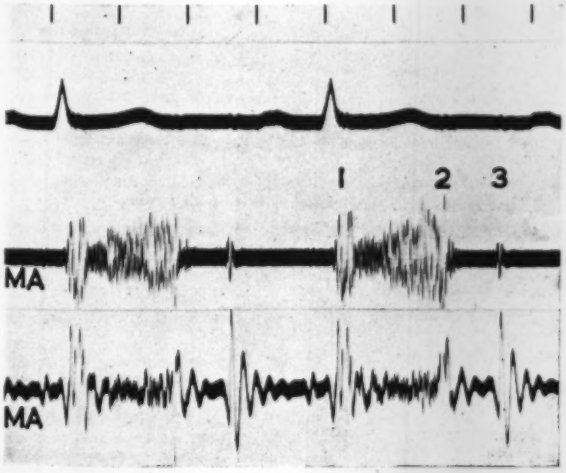
While the purpose of this brief sketch has been to show some methods of investigation and the need for them owing to the achievements of modern surgery, it must be remembered that important advances have been made in the medical treatment of heart disease. Heart failure can be satisfactorily controlled in most patients by means of the low sodium diet, the use of anti-coagulants has improved the prognosis in patients suffering from coronary thrombosis, and methonium compounds can be used to reduce the blood pressure in patients suffering from hypertension.

Fig. 5 (right): *apparatus for phonocardiography. Microphones placed over the heart lead to amplifying and photographic recording apparatus in the background.*

found it possible to attack the stenosed pulmonary infundibulum or valve directly and relieve the obstruction. It has long been possible to ligate a patent ductus arteriosus and this particular operation is specially attractive since it results in a normal heart. Operations are now being developed to sew up defects between the two auricles, and this again should result in a normal heart. For some years it has also been possible to alleviate coarctation of the aorta by resecting the narrow part of the vessel. One of the difficulties has been to bridge the gap if the abnormal area has been large. The use of grafts has been an important recent achievement.

Rheumatic heart disease, especially mitral valve stenosis, is much more common than congenital heart disease and is said to be present in two per cent. of the population. Dramatic relief of symptoms has resulted from operations devised to enlarge the narrowed mitral valve. Unfortunately in some cases there is incompetence of the mitral valve as well as stenosis and no satisfactory operation has yet been devised for this. In the same

Fig. 7. *Phonocardiogram recorded from a patient with mitral incompetence showing a murmur filling systole between the first (1) and second (2) heart sounds without a diastolic murmur. This patient could not be helped by surgery.*



Hypothermia in Cardiac Surgery

by C. E. DREW, M.V.O., F.R.C.S., Westminster Hospital.

HYPOTHERMIA implies a body temperature which is well below normal although at present there is no exact definition as to when the hypothermic state has been reached. It may occur naturally in a hibernating animal, the temperature of which may fall as low as 40°F. and this is accompanied by lowered metabolism with a corresponding decrease in its oxygen requirements.

Bigelow in Toronto was the first to study the effects of low temperature on non-hibernating animals with a view to its use in surgery of the heart and great vessels. He showed that nerve tissue (which is most sensitive to lack of oxygen) and the heart itself can tolerate temporary interruption of the blood circulation for much longer periods when the body temperature has been lowered by cooling. This means that if the surgeon wishes to operate, for example, within the right atrium, he can clamp the great veins entering it in order to provide a bloodless field, knowing that the patient will tolerate this temporary occlusion for a longer period at a low temperature than would be possible at the normal level.

However, it must be understood that hypothermia is of limited value, as even at very low body temperature it is not possible to interrupt the circulation with survival for longer than about 15 minutes. There are other advantages which accrue from employing hypothermia even if the heart is not explored.

Advantages of Hypothermia

Children with cyanotic congenital heart disease, the so-called ' blue-babies ', who suffer from chronic lack of oxygen tolerate this deficiency much more readily when cooled and are therefore better risks during surgical operations. Because blood coagulates less readily the cooler it becomes, procedures which involve vascular anastomoses such as the Blalock operation are less likely to be marred by thrombosis at the suture line. Low temperatures produce unconsciousness so that below a certain level no anaesthetic agent is required. It seems that young immature animals can tolerate low body temperature better than their elders who are prone to cardiac irregularities which may lead to death.

Methods of Cooling

Three methods of cooling in use at the present time are:

1. external cooling by means of a ' blanket ' wrapped around the patient, through which is circulated cold water or brine;

2. internal cooling, in which an artery or a vein is cannulated and the blood passed through a cooling coil after which it is sent back to the body via another vein;

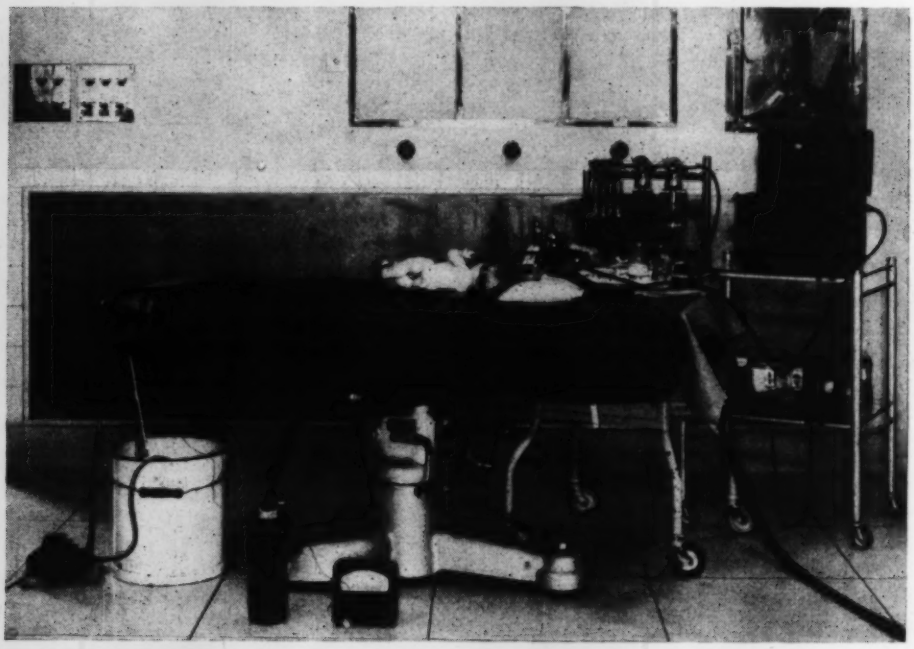
3. chemical cooling by means of drugs.

The technique in which blood is constantly removed from the body, cooled and then returned is a complicated one, but produces a fairly rapid rate of cooling and is probably the best method for use in the adult. Chemical methods may eventually supersede all others, but at present the pharmacological action of the drugs used is not completely understood and they have unpleasant and dangerous side reactions. The use of external cooling is simple and is ideal for a child, whose surface area is much greater in relation to its bulk than that of a full-grown adult. Whereas it may take one-and-a-half to two hours to lower the temperature of an infant to 78°F., it may take eight hours for an adult of average size.

Technique of External Cooling

After the usual premedication the child is given a small dose of a barbiturate such as Pentothal, and oxygen through an endotracheal tube. A curarizing agent is administered to prevent shivering, which is a natural reaction designed to maintain body temperature and which would retard the cooling process.

The patient is then placed on the blanket which is made of waterproof material containing a series of coiled tubes joined together, through which is circulated cold brine. Fig. 1 shows a model on such a blanket. A small pump maintains a continuous circulation of fluid through the coiled tubes from a bucket, which also receives the outflow for recirculation. A thermometer records the temperature of the latter which must be a



THE COOLING BLANKET

Fig. 1. *a doll is used to demonstrate the application of external cooling for hypothermia before operation. The doll lies on the blanket of waterproof tubing through which is circulated fluid a few degrees above freezing point.*

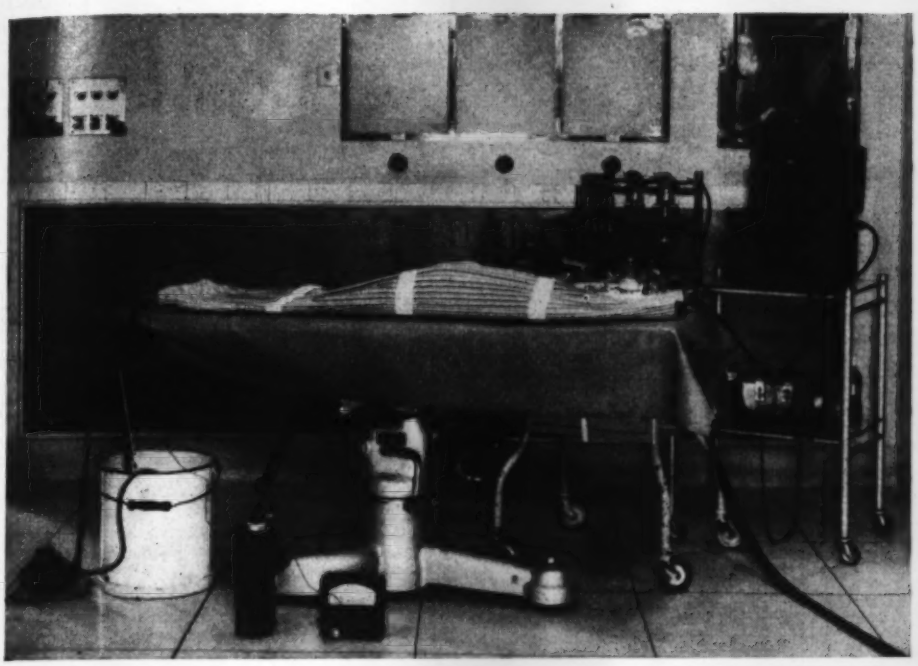


Fig. 2. *the same as Fig. 1 with the blanket containing circulating fluid folded over the doll until the desired temperature is reached, e.g. 72°-78° F.*

NINE-HOUR PERIOD CHART

Fig. 3. (below): *chart showing temperature and pulse rate from 9 a.m. to 6 p.m., of a patient three years of age, in relation to periods of anaesthetic, when covered by special blanket, and during and after operation.*

few degrees above freezing point to prevent damage to the skin and superficial tissues. A thermo-couple inserted high in the rectum records very small variations in internal temperature.

The electrocardiograph to the right of the anaesthetic apparatus is used when required during the operation. Not shown is the intravenous drip transfusion which is started before the induction of anaesthesia.

Fig. 2 shows the blanket closed over the patient until the operation is ready to take place.

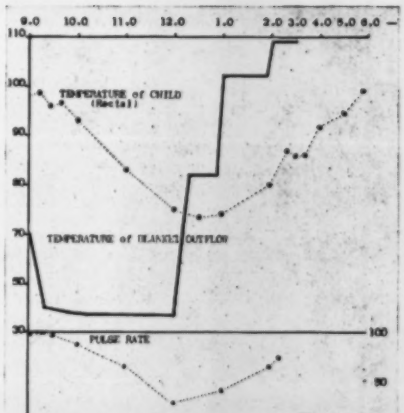
Temperature During Operation

The temperature desired is usually 72°-78°F. depending upon the type of operation anticipated and to what extent this is likely to interfere with the circulation through the heart. When the pump is stopped the temperature continues to fall for a few degrees and this must be appreciated otherwise a dangerously low level may be reached. Spontaneous respiration ceases at approximately 82°F. and controlled respiration with pure oxygen is carried out by the anaesthetist. No anaesthetic agent is required as the patient is unconscious at this temperature. There is no rapid rise in internal temperature when the blanket is opened because the atmospheric temperature is still below that of the patient, who in any case is still partly in contact with the cooling surface.

The chest is opened and the appropriate surgery is carried out. When the heart and lung are exposed, packs soaked in cold saline are used to prevent local warming due to heat generated by the operating lamps and the surgeon frequently rinses his hands in a similar solution. There is no appreciable difference in the appearance of or the bleeding from the tissues of a cooled patient.

As soon as the operation nears completion rewarming takes place by circulating warm water through the blanket and controlled respiration with oxygen is continued until the patient breathes spontaneously. Consciousness returns later and during this period the patient is returned to the ward and placed in a bed warmed either by an electric blanket or hot-water bottles, and covered by an oxygen tent. An electrically-heated bed is preferable as the temperature is everywhere constant and can be regulated.

On leaving the operating theatre the rectal thermo-couple is removed and an alcohol thermometer used to record body temperature, which is observed at frequent intervals until it is sufficiently high to be recorded by a mercury clinical thermometer. It is important that all thermometers are checked beforehand to make certain that they show similar readings at any given temperature. The alcohol thermometer is particularly liable to inaccuracy and in one of our cases the body temperature was raised to 104°F. because of the use of an unchecked thermometer. Luckily the patient came to no harm. As soon as normal temperature is reached, the nursing of such a patient is no different from that of a child who has undergone thoracotomy at normal temperature.



Case Report

Fig. 3 shows in graphic form what occurred when a deeply cyanosed child, aged three years, suffering from Fallot's tetralogy, was submitted to operation. This consisted of an anastomosis between the left subclavian and the pulmonary arteries (Blalock's operation).

Anaesthesia was started at 9 a.m. when the body temperature was 98·6°F. and the pulse rate 100 per minute. The patient was completely covered by the blanket at 9.45 a.m. when the temperature of the outflow was 34°F. At 11.15 a.m. the body temperature had fallen to 81°F., the pulse rate was now only 60 per minute and controlled respiration was instituted. About 15 minutes later the patient was partly uncovered and the operation began and continued for 100 minutes. During this period the temperature fell to

72°F. and the lowest recorded pulse rate was 32 per minute.

It will be seen that even after rewarming began, about half-way through the operation period, the rectal temperature continued to fall, but then steadily rose. Consciousness returned at 92°F. and normal temperature was restored at 6 p.m.

Thus two hours elapsed after cooling had begun before the operation could be started, and it took five hours after the completion of surgery before normal temperature was reached. The latter period could be reduced by active rewarming carried on for a longer time. In this case the child was taken out of the blanket as soon as spontaneous respiration occurred at 82°F. This patient made an excellent recovery.

Many similar operations have now been carried out using hypothermia, which appears to be a safe procedure in children. Several cases have been recorded in which the veins entering the heart have been clamped to allow one or more of the cardiac chambers to be opened without loss of blood, so that congenital abnormalities such as septal defects may be repaired.

It is unfortunate that the human body will not withstand the extreme low temperature to which the hibernating animal is accustomed. The apparently safe low limit is approximately 72°F. but below this the heart becomes irritable and is prone to develop ventricular fibrillation which is an extremely dangerous condition. However, the method does increase the scope of surgery of the heart and great vessels, and until some other way is developed of allowing the surgeon to operate within the heart in a bloodless field without hurry, it will continue to be a useful aid.

ADRENALECTOMY

A Case Study

by
ELSIE C. HALL,
Ward Sister,
St. Bartholomew's Hospital, London.

A HOUSEWIFE, aged 45, was first admitted to hospital in December 1952 with a lump in her right breast which she had noticed, but ignored, six months before. The diagnosis was a carcinoma of the right breast, and on December 18 right local mastectomy was performed, followed by a full course of deep X-ray. The histology of the breast confirmed the diagnosis. She attended the ward follow-up regularly and was quite well until August 1953, when she complained of pain in her back and right leg; she could only walk with the aid of sticks. X-rays showed the presence of secondary deposits in her pelvis, fourth and fifth lumbar vertebrae, and ribs.

She was readmitted on September 2, and five days later a bilateral oophorectomy was performed. The liver contained numerous secondary deposits. The operation was followed by a course of deep X-ray to the lumbar spine and pelvis, and a course of testosterone, 50 mg. daily, was begun on September 24. In spite of these measures the bony metastases progressed and the right ischio-pubic ramus fractured. Secondary deposits appeared in the upper ends of both femora, in other ribs, and the left scapula. Testosterone was discontinued on December 2.

The patient at this time presented a very serious medical and social problem. She was bedridden, but feeling extremely well, with a good appetite and an obvious increase in weight; she was free from pain and agitating to get up. There was no one at home to care for her except a delicate husband who has since been admitted to hospital himself with pneumonia, pleural effusion, and secondary thyrotoxicosis.

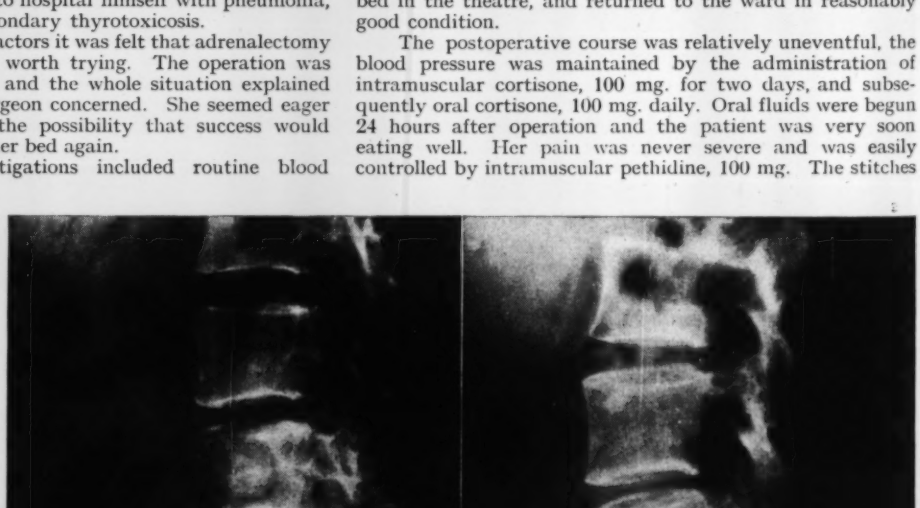
In view of all these factors it was felt that adrenalectomy was justifiable and well worth trying. The operation was described to the patient and the whole situation explained very carefully by the surgeon concerned. She seemed eager to take the risk, with the possibility that success would enable her to get out of her bed again.

Pre-operative investigations included routine blood examination and chemistry, 17 ketosteroids estimation, and a vaginal smear which showed high oestrogenic activity.

The operation was fixed for December 7. The patient was prepared in the routine way for any major operation, with the addition of oral cortisone, 100 mg., the day before the operation, and intramuscular cortisone, 100 mg., on the day of operation. (It must be remarked here that subsequent patients for bilateral adrenalectomy have been prepared with oral cortisone, 100 mg. twice daily for 10 days, and intramuscular cortisone, 100 mg. daily for two days, before operation.)

The patient went to the theatre at 9.30 a.m. on December 7 and returned to the ward at 2 p.m. having had a bilateral adrenalectomy. Dissection of the left gland had been comparatively easy, but the right gland was lying posterior to the inferior vena cava, considerably higher than was expected. Its position made dissection very difficult but the gland was removed in three pieces. The suprarenal vein on this side was very short and it was found impossible to tie it, so a stitch was passed through the inferior vena cava and the vein tied off with the thread. The wounds were closed without drainage. Intravenous fluid was given throughout the operation. The patient was put into her bed in the theatre, and returned to the ward in reasonably good condition.

The postoperative course was relatively uneventful, the blood pressure was maintained by the administration of intramuscular cortisone, 100 mg. for two days, and subsequently oral cortisone, 100 mg. daily. Oral fluids were begun 24 hours after operation and the patient was very soon eating well. Her pain was never severe and was easily controlled by intramuscular pethidine, 100 mg. The stitches



Lumbar spine before and 70 days after adrenalectomy.

Pelvis before and 70 days after adrenalectomy.

were removed on the 12th postoperative day, and the wounds were soundly healed.

On December 27—three weeks after operation—she was lifted out of bed to sit in a chair.

On January 8 all her bones were re-X-rayed and recalcification was seen in nearly all bones previously invaded by deposits.

With this heartening information the patient was allowed to begin weight-bearing on her legs. Her rehabilitation was slow—she had been bed-ridden for four months and treated with extreme care, and was consequently rather nervous of herself. Her physiotherapist showed great patience with her, and she gradually regained confidence and strength. By February 12 she was able to manage a walk up and down stairs and on February 16 she left hospital for a period of convalescence. At this time she was taking oral cortisone, 25 mg. twice daily.

On March 23 the patient came to visit us. She was looking well and happy; she walked in unaided, and was extremely pleased with herself. It was most cheering to see this patient mobile and apparently well, after she had been bedridden with very little hope for the future.

[I wish to express my thanks to Mr. J. B. Hume, M.S., F.R.C.S., for permission to write this case study, and to Mr. N. K. Harrison of the Department of Medical Photography for permission to use the photographs.]

At Battle Hospital, Reading

THE opening of a new outpatient and casualty department, chest clinic and nurses home at Battle Hospital, Reading, marked an important step in the development of this large hospital in the Reading area hospital and nurse training school group. The ceremony was carried out by H.M. Lieutenant of the County of Berkshire, H. A. Benyon, Esq., under the chairmanship of Mr. F. H. Aitken Walker, F.R.C.S., after the new buildings and the patients and nurses who will use them had been blessed by the chaplain to the Reading Area Hospitals, the Rev. E. T. Hood.

Mr. Walker spoke of the work that had been accomplished since the Reading Hospital Group had been formed under the National Health Service Act. With the growth of the town of Reading, there has long been a need for an enlargement of the facilities for casualty and outpatient work. The new departments are adaptations of old buildings. The ground floor of one of the old hospital blocks contains a surgical and casualty outpatient department, with examination rooms, dressing cubicles, operating theatre, plaster room, X-ray department and recovery room. The whole is served by a large waiting room, with a canteen and comfortable canvas stackable chairs. The dressing cubicles communicate by hatches with the sterilization room, which is provided with all modern equipment.

The centre of the block is set aside for the patients' entrance and record-keeping, while the other end contains a large medical clinic with a number of curtained examination and treatment cubicles, and the dispensary from which the patients obtain the medicines ordered for them. These departments are very conveniently sited, so that the patients' time and energy are conserved. A special entrance for ambulances leads direct to the main surgical examination and reception rooms.

The chest clinic occupies the block previously used for outpatient and casualty work. It is on two floors, and has its own new X-ray department together with consulting, examination, waiting and treatment rooms. Both these buildings have been redecorated throughout in ivory paint.

The nurses home is a new building and provides 25 additional bedrooms for sisters and staff nurses. It stands well away from the hospital buildings, and looks on one side over Battle farm and on the other over an open space round which the board of management plans to build two similar blocks as funds become available—for at present over 100 beds are empty in blocks which are to be redecorated and modernized when sufficient nursing staff can be recruited.

Certainly the standard of comfort provided in the new home should attract permanent members to the staff. In addition to a large and a small sitting-room, kitchen, utility and shampoo rooms, the individual bedrooms are delightful. Furnished in light oak, with bed, bedside table and reading lamp, two chests of drawers, one with writing desk and dressing-table, easy chair and an occasional table, the rooms are in four different colour schemes—pastel shades of blue, green, pink and beige have been chosen for the curtains and bedcovers and the paint of doors and built-in wardrobe, except that the pink furnishings are repeated in the beige rooms for greater effect. The rooms are of good size, and there are two delightful bathrooms on each floor with gay spotted plastic curtains. Together with the colours of the furnishings and the delightful flower arrangements which Lady Gwenllian Palmer had herself prepared, the new building looked a 'home' that everyone would want to return to and enjoy.

Among those present were Lady Palmer, Mrs. Benyon, C.B.E., chairman of the management committee, Col. C. B. Krabbe, O.B.E., vice-chairman of the Oxford Regional Hospital Board, the Mayor and Mayoress of Reading, Councillor A. E. and Mrs. Smith, Miss Aldwinckle, matron of the Royal Berkshire Hospital, Miss D. Brace, matron of Battle Hospital and many members of the medical, nursing and other staffs and friends of the many hospitals in the group. (Pictures next week).

Prizegiving Ceremonies

—AT THE NURSING SCHOOLS

Above: *at CHESTERFIELD AND NORTH DERBYSHIRE ROYAL HOSPITAL, where the Duke of Devonshire (centre) presented the awards. The silver medallist was Miss E. M. Barber.*

Top of page: *prizewinners at PUTNEY HOSPITAL, with, centre, Miss Cochrane, lately matron of Charing Cross Hospital, who presented the prizes, and Miss E. M. Smith, matron. Miss Fisher, sister tutor, is second from left.*

Above: *TUNBRIDGE WELLS SCHOOL OF NURSING prizegiving was held at Pembury Hospital. Prizewinners, left to right: Miss L. Trucchi, surgery, Miss B. Morris, sister tutor's, Miss A. Clarke, medicine, with Miss B. Austin, gold medal.*

Above: *at SALISBURY GENERAL INFIRMARY Mr. Hector Bolitho presented the awards. Miss E. Folmer and Miss E. Kolkmeyer received senior prizes, and certificates of training in the Plastic and Oral Surgery Department were presented.*

Right: *at the first prizegiving of NORTHOWRAM HALL HOSPITAL, HALIFAX Mrs. Eric Denham presented prizes to Mr. R. Horsfield (medical) and Mr. A. G. Smith (nursing). Miss Moir, matron, is in the third row (right), and Mrs. Denham in the second row (left).*

Left: *at PARK HOSPITAL, HITHER GREEN. Front row, extreme left: sister tutor; fourth from left Mr. Gillinder, who presented awards; Miss Bell, matron, Lewisham Hospital, and Mr. W. R. Owen, chairman, Lewisham Group Management Committee.*

The Educational Background of the Nurse

by VOUSDEN WATKIN, S.R.N.

IT is the expressed and official policy of the General Nursing Council for England and Wales to re-introduce a minimum educational standard for intending nursing students. The Council has not, however, as yet found itself in a position to implement this policy.

The case for a minimum educational standard is a strong one and it has a dual aspect. Firstly, there are good reasons for holding that a certain educational background is necessary for the nurse of today, and secondly, any but a nominal restriction of entry by this means would carry far-reaching implications with regard to the whole future structure of the nursing profession.

The first point I wish to make is a familiar one; it constantly crops up in reports on wastage during training. A student nurse may find the technical and intellectual side of the work too much for her. She may realize this, or she may resentfully consider that too high a standard is expected. In the first case, time and trouble has been wasted both by the tutor and the student. In the second case the profession will in addition be damaged by the bad impression spread by a disgruntled ex-student. I feel, however, that it is even more unfortunate when such a person does not fall out during training, but is allowed to stay on, and perhaps scrape through the final examination; she then has to shoulder responsibilities to which she is not equal and suffers considerable anxiety on account of this. Her mental conflict may well be reflected in her relations not only with her colleagues but also with the patients and students for whom she is responsible. Such situations could be avoided without loss to the hospital's numerical strength if people who are unsuitable for general training were encouraged to become orderlies, or train for State enrolment, thus saving unpleasantness for themselves and the tutor's valuable time and skill.

A Liberal Education

There is also a more subtle side to the problem, which is commonly overlooked. I am convinced that literacy plus a technical training and a kindly disposition are not enough to make a satisfactory State-registered nurse. The concept of a liberal education seems to have passed out of fashion, yet that is what is needed. The nurse needs the humane background, the balancing of her personality, the capacity for abstract thought and idealism which such an education alone can give. Contact with the finest minds and thoughts and the beauty of all the ages cannot leave one altogether unmarked for the better. Especially will a nurse who tries to live up to the ideal of one who can put all sorts and conditions of men at their ease and have satisfactory human relationships with them need to know how the other half lives.

Also, nursing is noted for its traditions, and those traditions are based on an idealism which was fundamental to the personality of the founder of professional nursing. For a nurse to become a real part of the profession she must be able to enter into these traditions and, in certain measure, give herself to them.

For this wider perception and imagination to be formed, the mind must be trained; and a basic education ending at 15 years of age is not sufficient. It is vital for the sake of her patients that the nurse should have an interesting personality and since modern education seeks to develop the individual as a whole, this is more likely to be attained in the case of a girl or boy who leaves school at 18, rather than at the minimum age.

The lowering of the standard since 1939 when the General Nursing Council withdrew its Test Examination has had two main effects: (*a*) it has opened the doors of the profession to those whose general background is too poor for them to become useful members of it, and (*b*) it has led to a lowering of the public esteem in which nurses were formerly held, and probably caused some people of a high standard of education, who would normally have considered a nursing career, to take up work in other spheres. An element of social snobbery may even enter into this aspect, and one can see the wisdom of Miss Nightingale's preference, in the days when a good education went with gentle birth, that candidates for nurse training should be ' young ladies '. That proviso should not be necessary in our day of equal educational opportunity for all, but it must be remembered that social status is, to some extent, related to the type and duration of education and it seems that such considerations do, in fact, have some effect still.

Effects of Uniform Educational Requirement

Now let us suppose that a uniform educational requirement were introduced. What effects would its operation produce on the structure of the nursing profession ? Taking the statistics of the 1947 Working Party as a basis, I suggest that if the adopted level were equivalent to the requirements of university entrance, recruitment for full training would at first drop by about 80 per cent. This sounds drastic, but many of those excluded on educational grounds could be trained for enrolment and the overall effect on the staffing situation should be great. The principal effect would be that since pupil assistant nurses would qualify comparatively quickly, the wards would come in time to be mainly staffed by pupil assistant rather than student nurses.

This widening of the assistant nurse's sphere would bring increased status for her and her training could be broadened accordingly, though I doubt if longer than 18 months' training would be necessary, since separate Rolls might be kept for general, mental, fever and possibly also for other types of work.

The small number of students training for State-registration would force on the profession the realization that they must be trained as administrators and teachers, given the best possible training and the status of students. Better selection would, in itself, be a potent weapon against wastage and it might reasonably be expected that the majority of people who start the course would finish it and go on to posts of responsibility. The time released by the removal from student nurses of the burden of staffing the hospitals could be utilized to give a full comprehensive training, thus unifying the profession and abolishing the necessity for separate registers.

An incidental advantage of this scheme is that the registered nurse who worked in the mental field would be known by the same name as her colleague in the general, thus dispelling the illusion that the mental nurse is in any way inferior in status or training to the general nurse.

Parity of Esteem

The vast improvement in status ensured by a restricted level of entry would cause significant repercussions on the nurse's position in comparison with the other professions. I suspect that the way in which some medical men at present refer to nurses as their ' colleagues ' is in part an act of chivalry directed towards the female majority of the profession, and in part a posthumous tribute to Miss Nightingale, before whose stormy genius even they, in their day, had to bow. But if the registered nurse's general and professional education were of a level comparable with that required by the established and graduate professions, it would strain no one's charity to grant us parity of esteem. With parity of esteem would come greater opportunities for service as

nurses were able to play a larger part in administration and policy formation in the National Health Service, and possibly some tangible recognition of the nurse's enhanced value, such as a salary worthy of the responsibilities carried by senior grades, might even be forthcoming.

What Level Required?

Now we come to consider what educational level should, in fact, be required. The graduate professions naturally demand university entrance level. Exemption from the preliminary examinations of the Law Society and the Institute of Chartered Accountants can also be obtained through the General Certificate of Education. I think that once the necessity for the nurse to have a sound and liberal education is admitted there can be no denying the convenience of adopting so widely recognized a standard. In addition there is the by no means insignificant point that such a step would ease the way for the introduction of a degree in nursing and would make the profession more acceptable to the academic authorities, who are, quite rightly, concerned to see that the standards and traditions of the British universities are not sacrificed to the demands of technical or purely vocational training.

By the exertions of Miss Nightingale nursing was raised in the 19th century to a position of respectability and esteem; a cardinal point in her policy was the training of *educated* women to supervise and train others. With the call for greater numbers and more training schools it became difficult to obtain enough students of sufficient calibre to carry on Miss Nightingale's traditions. The nursing profession will suffer greatly if this trend, this slide down the slippery slope of flexible values, is allowed to continue, but, as in so many other things, a loyalty to our past can save us. Quantity can never be a satisfactory criterion for nurse training; quality must come first. However, a good training, like a good house, must have sound foundations, and the nurse's foundations are laid in her general education, her upbringing and her experience of life, the first of which, at least, is reasonably susceptible to measurement.

During the Florence Nightingale Centenary year, we are serializing Sir Edward Cook's famous biography of the Crimean heroine; 41st instalment.

Florence Nightingale

One of Miss Nightingale's most important contributions to nursing in this country was the notable experiment in the Liverpool Workhouse Infirmary in which Nightingale-trained nurses were introduced by Mr. Rathbone with Miss Nightingale's active collaboration. The experiment was so successful that she resolved that it should be extended to London workhouse infirmaries. She approached Mr. Villiers, President of the Poor Law Board, and with him, and with his right hand man, Mr. Farnall, was soon deeply immersed in political manoeuvres to obtain the necessary legislation. But just as success seemed assured, the Government fell, and Mr. Villiers was out of office. The opportunity had passed.

MISS NIGHTINGALE, however, was not one to waste time in empty lamentations. She had to begin over again, that was all; and she wrote at once, as we have already heard, to the new Minister. She also procured an introduction for Mr. Farnall to Lord Derby, and the Prime Minister seemed sympathetic. Mr. Hardy had answered politely, but did not follow up his letter, and and his first move seemed sinister. He dismissed Mr. Farnall from Whitehall and sent him to the Yorkshire Poor Law District. The anti-reform party was believed to have gained the ascendant.

But now a fortunate thing happened. Mr. Hardy made a speech in which he implied that the existing laws were adequate, if properly enforced, to meet the case. There was a measure of truth in this: previous legislation had *empowered* Guardians to separate the sick, but had set up no administrative or financial machinery, so that, in practice, his argument was fallacious; and, in any case, Mr. Hardy's remark was a reflection on his predecessor's administration. This nettled Mr. Villiers greatly; he was "not going to sit down under it", he said; he became red-hot for reform; very much on the alert, too, to trip his successor up. Miss Nightingale did not fail to add fuel to the flame. Mr. Villiers corresponded with her and saw her repeatedly; reported all he was able to learn of how things were going at Whitehall, and begged her to do the like for him. "The public are led to infer", he said to her, "that nothing was needed but a touch from Mr. Hardy's wand to set all things straight." The public, thought Miss Nightingale also, would soon discover his mistake. Mr. Hardy would find that he had either to do nothing, or to legislate; unless indeed the Tory Ministry were overthrown first.

Now, Miss Nightingale was a Whig, and she would have been glad to see the Tories out and Mr. Villiers in again at the Poor Law Board. But there was something that she cared about a great deal more, namely, that the neglect of the sick poor should be remedied at the earliest possible moment; and as the Tories might after all weather the storm, she must see what she could do to get a Poor Law Bill out of them. In the autumn Mr. Hardy appointed a Committee, mainly composed of doctors, to report "upon the requisite amount of space, and other matters, in relation to workhouses and workhouse infirmaries." One of the "other matters" was nursing, and the Committee, instead of expressing an opinion on this, asked Miss Nightingale to send them a Paper.

She made full use of her opportunity. Her Memorandum (Jan. 19, 1867) pointed out that the question of nursing could not, either in logic or in effective practice, be separated from that of administration. "In the recent inquiries", she wrote, "the point which strikes an experienced hospital manager is not the individual cases which have been made so much of (though these are striking enough), but the view which the best Matrons, the best Masters, and other officials of the workhouses give from their own lips (in evidence) of what they considered their duties. These bore as little reference to what are usually considered (not by me alone, but by all Christendom) the duties of hospital superintendents as they bear to the duties of railway superintendents . . . I allude to the heaping up of aged, infirm, sick, able-bodied, lunatics, and sometimes children in the same building instead of having, as in every other Christian country, your asylum for aged, your hospital for sick, your lunatic asylum . . . each under its proper administration, and your able-bodied quite apart from any of these categories . . ." And she went on to outline her general scheme.

In accordance with her usual custom, Miss Nightingale had copies of her Paper struck off separately, and circulated them among influential people. She put her point of view with a touch of exaggeration characteristic of her familiar letters to Captain Galton, one of the members of the Com-

mittee. "I look upon the cubic space as the least of the evils—indeed as rather a good, for it is a very good thing to suffocate the pauper sick out of their misery." Meanwhile she thought it wholesome that the "ins" should know that the "outs" did not mean to let the subject of Poor Law Reform be shelved. "I have had a great deal of clandestine correspondence", she wrote to a friend who might pass the information on (Oct. 28, 1866), "with my old loves at the Poor Law Board these last two months. The belief among the old loves is that the new master is bent on—doing nothing.

Mr. Hardy kept his own counsel and made no sign. As the session drew near, Miss Nightingale became anxious, and poured in letters and memoranda upon him. In one of these she made what turned out to be an unfortunate mistake. She was too frank. She was pressing upon Mr. Hardy's attention the importance of the Liverpool experiment, and she said, incidentally, that there had been difficulties. Mr. Hardy misinterpreted the remark and made use of it in the House of Commons to explain why he did not propose to take any direct action in the matter of nursing reform. Indirectly, however, his proposals did a great deal. On February 8, 1867, Mr. Hardy introduced his Bill. So, legislation had, after all, been found necessary to meet the demand that something must be done.

But Miss Nightingale's administrative mind saw chiefly, and at first saw only, the measure in which the Bill fell short of logical perfection. It was a tentative measure; it was largely permissive; it did something to separate the sick and children from the ordinary paupers, but it did not do all. Moreover, it did nothing expressly to improve workhouse nursing. Miss Nightingale pronounced the Bill, therefore, "a humbug". She tried hard to get the Bill amended and extended. Mr. Villiers was as critical as he could reasonably be in debate but the real fact was that the Bill made a great and a surprising step in the direction which Miss Nightingale had pressed upon him. The reforms made by the Bill were sufficiently beneficent. The whole of the unions and parishes in London were formed into one district, "The Metropolitan Asylum District", for the treatment of insane, fever and small-pox cases, which had hitherto been dealt with in the workhouses. Separate infirmaries were formed for the non-infectious sick, with a greatly enlarged cubic space per inmate. Dispensaries were established throughout the metropolis. Above all, the "Metropolitan Common Poor Fund" (Miss Nightingale's "Hospital and Asylum Rate") was established.

A BEGINNING

When the battle was lost—or won—Miss Nightingale counted up the gains, and said, "This is a beginning; we shall get more in time." And this has been the case. The principles implied in the 1867 Act—the separation of the sick from the paupers, and in the case of London the making medical relief a common charge—are the principles for which Miss Nightingale contended. Her influence in forming the public opinion which made the legislation of 1867 possible was referred to in both Houses of Parliament: by Mr. Villiers in the House of Commons; and in the House of Lords by the Earl of Devon. The latter, in moving the second reading of Mr. Hardy's Bill, said: "It would be improper on such an occasion to omit reference to the improved feeling on the subject which has resulted from the admiration the country must feel for the exertions of that excellent and gifted woman, Miss Nightingale, whose name would always be received with that respect which was due to her Christian activity and self-devotion."

Soon after the Act came into operation, to the improvement of London workhouses, the pioneer of improved workhouse nursing died in Liverpool. The work of Miss Agnes Jones had gone on with ever-increasing success, and the results were so satisfactory that in March 1867 the Liverpool Vestry decided to extend the trained nursing to the female wards and to throw the whole cost upon the rates. When the strain of the increased work was at its severest, Miss Jones was attacked by fever, and she died on February 19, 1868.

A regular order with your bookseller or newsagent will make sure of your *NURSING TIMES* each week.

Her death involved Miss Nightingale in much anxiety and additional responsibility. "I believe I have found a successor at last", she wrote to Madame Mohl. "I don't think anything in the course of my long life ever struck me so much as the deadlock we have been placed in by the death of one pupil—combined, you know, with the enormous *jaw*, the infinite female ink which England pours forth on 'Woman's Work'. It used to be said that people gave their *blood* to their country. Now they give their *ink*." Miss Nightingale's first concern was to put heart and strength into the nurses who were now deprived of their Chief. Writing as their "affectionate friend and fellow-sufferer", she called upon them to fight the good fight without flinching. "The nurses have been splendid", she was able to report presently.

OUTCOME OF LIVERPOOL EXPERIMENT

The Liverpool experiment, rendered successful by the devotion of Agnes Jones, rapidly made its mark. In ten years' time the system of employing pauper inmates as nurses had been entirely superseded, in all sick asylums and separate infirmaries, by paid nurses. In 1897 the employment of pauper nurses in any workhouse was forbidden, and the training of the paid nurses has been continuously improved. To Miss Nightingale, here as in all her undertakings, each point gained was only a step on the road to perfectibility. Among some communings with herself, written in 1867, there is this entry: "Never think that you have done anything effectual in nursing in London till you nurse, not only the sick poor in workhouses, but those at home."

Meanwhile Sir John Lawrence's term of office in India was coming to an end, and Miss Nightingale, regarding him as the indispensable man, looked upon this event as one almost comparable to the death of Sidney Herbert. Before Sir John Lawrence retired, the mainspring of the machinery for sanitary progress in India must be inserted. Miss Nightingale had a clear policy in her mind, and she secured most of her points with a celerity and a completeness which entitle this episode to rank among her most brilliant campaigns. What she sought to attain was an efficient machine which would turn out sanitary improvement in accordance with the best knowledge of the day and of which the working would be subject to the propelling force of public opinion. She therefore set herself to secure (1) an executive sanitary authority in India, (2) an expert controlling (and, incidentally, an inspiring) authority in London, and (3) the publication of an annual report on the work done, so as to make both parts of the machinery amenable to public inspection.

On the first of these points, Miss Nightingale was doomed to some disappointment. Neither at this time, nor in her later years was any supreme and executive sanitary machinery established in India. But on the other two points, stated above, she was at the time completely successful. She had in all this a valuable ally. She made at this time a friendship with one whose disinterested devotion to the cause of sanitary reform in India equalled her own, and whose co-operation was of the greatest value. The new friend was Sir Bartle Frere.

In May 1867, the question of the Public Health Service in India had slumbered for more than a year, Miss Nightingale determined to wait no longer. She wrote to Captain Galton that she had been "strongly advised to communicate direct with Sir Stafford Northcote"; what did Captain Galton advise? He agreed that things were not going well, and was glad that she meant to move. He would give her an introduction to Sir Stafford, and he advised her to see Sir Bartle Frere, "as I fancy you could make him useful". He had just returned from the governorship of Bombay, and had been given a seat on the India Council in London. A fortnight later he and Miss Nightingale met.

Miss Nightingale must have impressed Sir Bartle Frere as greatly as he impressed her. He now became one of her constant visitors, and a busy correspondence began between them. "If only", she wrote to Captain Galton (July 24) "we could get a Public Health Department in the India Office to ourselves with Sir B. Frere at the head of it, our fortunes would be made."

(to be continued)

In a Hospital for Nervous Disorders

by BERYL W. BUTTON, S.E.A.N.

IF you have not had the experience of working in a hospital for nervous disorders, I think my experience may interest you. I have been working in general hospitals for nine years. Now I am having a long spell as a patient in a hospital for nervous disorders.

The first big difference I noticed was that almost every patient is allowed up and about; a bedpan is a practically unknown utensil. Each new patient stays in bed for the first day or two during observations and tests, but even so she is allowed up for the bath and toilet. Other patients according to their treatment or progress are allowed out in the grounds, or even into the town.

Secondly, I am amazed at the patience of the sisters and nurses who work in these hospitals. All patients have their particular difficulties. At times they lie dormant, at other times they rise to a degree of fury. *Never* at these times do the staff say they are too busy just now to bother. On the contrary, sister or nurse will listen with a kind patience to the outburst, will smooth the difficulty over and only leave the patient when she is calmed.

Thirdly, I am interested to see how quickly the staff in this type of hospital understand the character and personality of their patients. For various reasons most patients find it difficult to eat for the first few days after arrival. Some will manage with just a little coaxing, but some must definitely be fed by one or two nurses. These nurses just know with whom they can get results by kindness, or with which patients they must use strict firmness.

The different type of work for these nurses surprises me. Instead of the student nurse doing blanket baths and cleaning bowls, she is looking at photographs with a patient, drying the tears of a new patient just admitted, or helping to feed one of the difficult cases. Sometimes she sits on the verandah wall, able to watch us all, but also busily sewing name tapes on patients' garments. At any opportunity like this, nurse happily talks with patients on subjects outside hospital life.

For the staff nurse life must be extremely different. Generally she has no ward dressings and treatments. She seems to spend her time in various ways—giving out drugs; making an inventory of each new patient's belongings; recording in the mornings those to whom she has given nail files and scissors, and coming back again in the evening to collect them all in. She is responsible for the stock cupboard, where each patient's belongings are kept. Not just night clothes, but underwear, frocks, tennis shorts and rackets and many other things which can readily give the poor staff nurse a headache.

On what we as patients call 'treatment days' the staff nurse really has a particularly busy time. Twice a week electrical treatments are given and these patients require special care. From Monday to Friday each week deep insulin treatment is given. Work does not end when the patient is happily back in bed, for at any time she is likely to have a reaction. The nurse must then quickly get milk or food before a coma takes place.

It is the night nurse I am particularly sorry for. It is a foregone conclusion that a patient suffering from a nervous disorder will naturally suffer from sleepless nights; the night nurse goes round with sedatives which help a lot. However, there are always those patients who will wake in a frightened state and the nurse must use her soothing powers and repeat the sedative. Always there is the chance of a deep insulin patient going into a coma, which causes a complete upset. The reactions of these patients are sufficient to wake all in the ward while nurse and her assistant cope admirably until night sister answers the summons.

For the sister life must be a continual trial in patience. She must see that all her staff do their work competently. She must assure and inform visitors during those happy hours. And always there is a distracted patient who runs to sister in a time of fear or difficulty. Sister always has time for the tearful story, and the tact and knowledge to compose the patient again.

There is something so entirely different about the atmosphere between general hospitals and hospitals for nervous disorders.

In a general hospital a patient is in for some medical or surgical complaint, she may be treated splendidly but she does rather remain a number. Life is so hectically busy with ward dressings and treatments that the body remains a thing to be cured and is rather disassociated from the mind in whatever state that may be.

How different it is in a hospital for nervous disorders. On admission a doctor makes a general check-up to make sure that the physical condition of his patient is satisfactory. After that, as far as the patient is concerned, the body is forgotten, or at any rate put tremendously in the background. Slackness in regulations and interest in each individual's hobbies and a kind unruffled happiness is the aim at these hospitals. Each patient is a real person. What she thinks, feels and does is a help in diagnosis, treatment and cure.

For the nurse life must sometimes seem tiresome and exacting. But what a wonderful job! To help patients suffering from mental illness which is so harsh in its wretchedness.

Having nursed a patient through a tormented abstracted state and severe mental illness, I can think of nothing more satisfying for the nurse than to discharge a patient in a normal happy condition.

A RESEARCH STATION AND EXPERIMENTAL FARM

IT seems to be a tendency for pharmaceutical manufacturers to establish themselves in country surroundings, so one is not altogether surprised to find a firm of manufacturing chemists, such as Vitamins Ltd., with a research station situated in a rural scene, near Tadworth, Surrey, and a project for their London factory to move out to Crawley, Sussex. What is perhaps surprising is the beauty of Walton Oaks, the lovely country house which forms the research station. It is set in glorious gardens, and near the house is the experimental farm which is run on ordinary commercial lines as a farm, but is used for nutritional experiments on livestock. This firm carries on research in the nutritional requirements of both humans and animals to assist in the manufacture of its products; it manufactures a range of vitamin dietary supplements in addition to the well-known proprietary, Bemax.

Dr. Margaret Wright, M.R.C.S., L.R.C.P., M.B., B.S., and Dr. Audrey Baker, B.Sc., M.R.C.S., L.R.C.P., who lead the research team, are making interesting experiments with antibiotics as nutritional factors in the feeding of farm stock. They emphasize that the whole question is at present in the experimental phase—for example, although it is proved that pigs grow and fatten more quickly when a trace of penicillin is added to their diet, it is not yet known why this should be so. A theory is that the penicillin appears to make the animals more placid and less aggressive and quarrelsome, and that therefore they do not lose weight by unnecessary activity. Time is, of course, an important factor in the fattening of pigs because of the very heavy expense of feeding-stuffs. When fuller knowledge of the effects of a penicillin-supplemented diet is available it will open up a very wide question of its possible application to humans, but naturally, the danger of creating penicillin tolerance has to be kept in mind. These experts say that there is no danger to humans in consuming penicillin-dosed pork, owing to the very small quantity used.

A wide range of experiments in diet deficiencies and supplements is being carried out on rats at Walton Oaks experimental station—especially regarding the effects of various vitamin deficiencies on the fertility rate of rats, and the results of feeding dietary supplements. The rat's life cycle is so short (two years being about the maximum) that the time needed to gather the results is also correspondingly short. The results observed will form a valuable basis for study of the same factor in humans, and for the production of increasingly valuable diet and supplements. Work on the rats has already demonstrated that a diet with certain vitamin deficiencies can be applied in some cases without any observable signs of deterioration in the subject.

The doctors in charge point out the importance of this in its application to humans; individuals may be suffering from a deficiency of a certain vitamin without showing the characteristic signs of a vitamin-deficient diet on clinical examination.

The medical and scientific staff at this centre are working on the theory (in its human application) that undetected vitamin deficiency may have an adverse effect on fertility, still-birth and prematurity rates, more especially as it is known that individual vitamin requirements vary, apart altogether from difference in requirements at various stages of growth and age.

Founders of London Hospitals

by RACHEL GIBB

THE founders of London hospitals included a king's minstrel, a group of monks, a City Sheriff, an eccentric bookseller, a banker, several doctors (one of whom subsequently burgled his own hospital) and a Victorian lady who raised the money by making and selling artificial flowers. They founded hospitals in fulfilment of a vow taken in fear of death; as a gift to the Church; as the result of a military campaign; following the death of a relative; or simply in compassion for the suffering they saw around them. Some of them were themselves poor: one of the doctors, the son of a Yorkshire corn chandler, came to London with £5 in the world.

The oldest hospital in London, the Royal Hospital of St. Bartholomew, was founded by a man called Rahere, a minstrel at the court of King Henry I. While on a pilgrimage to Rome he fell sick and was near death; he vowed that if he was allowed to return home he would build a hospital for the sick poor. There is a legend that St. Bartholomew appeared to him in a vision and bade him found both a hospital and a priory in Smithfield, which was then an open swamp outside the city walls. He began to build in 1123—in the words of a contemporary writer, he "drew to himself children and servants, making himself as one of them, and with their help he gathered together stones and other things profitable to the building." His body lies at the side of the high altar in the church which he himself founded—St. Bartholomew the Great.

St. Thomas à Becket

Second in age is St. Thomas' Hospital, founded by the monks of the Priory of St. Mary Overy, Southwark. The exact date of its founding is unknown, but it was dedicated to the memory of St. Thomas à Becket. The priory was burnt down in 1212, and it was decided to rebuild the priory and the hospital as separate buildings. The Priory was rebuilt on the same site, and later became Southwark Cathedral; the brethren and sisters of the hospital moved to a new building farther east. The building of the new hospital was made possible by the powerful patronage of Peter de Rupubus, Bishop of Winchester, who granted an indulgence to anyone who contributed to the expense.

The last of the three surviving mediaeval hospitals is the oldest mental hospital in the world—Bethlem Royal Hospital, or Bedlam. In 1247 Simon Fitzmary, Sheriff of the City of London, gave his lands which lay outside Bishopsgate to the Church of St. Mary of Bethlehem, and the priory which was built thereon became a house for the insane. It must have been a grim and terrible place in its early days. Treatment of the mentally sick varied from whipping and chains to long-drawn attempts at exorcism; an inventory made in 1398 included "four pairs of manacles, eleven chains of iron, six locks and keys and two pairs of stocks". Patients who failed to respond to these savage remedies were discharged as incurable, and wandered away demented, ragged and starving, a terror to the countryside.

As all mediaeval hospitals were monastic foundations the Reformation saw the end of most of them. Only these three survived the tempest and continued as hospitals. No more were founded during the 17th century; there were pest houses for victims of the plague, but these dreadful places were more for the isolation than the treatment of sufferers. The next individual to found a hospital was a Governor of St. Thomas'; his name was Thomas Guy.

Thomas Guy

Thomas Guy was born in 1645, the son of a lighterman and coalmonger. When he was 15 he was apprenticed to a bookseller, John Clarke of Cheapside, and worked for him for eight years. He then set up his own shop on the corner of Cornhill and Lombard Street, with a stock worth about £200, chiefly bibles.

During his lifetime and from this beginning he founded almshouses; he built and furnished three new wards at St. Thomas' at a cost of £1,000 and he founded Guy's Hospital at a cost of £18,793. In his will he left lands and tenements in Staffordshire, Warwickshire and Derbyshire and over £300,000 in legacies, but throughout his life he ate his meals off a piece of newspaper spread over his shop counter, and if anyone visited him after dark to discuss business transactions which involved no reading or writing he would blow out the candles as an economy and carry on the conversation in the dark. At one point in his life he intended to marry one of his servants. He had undertaken to have the pavement outside his house repaired at his own expense, and he told this servant to instruct the workmen how far to do the repairs; she misunderstood him, and consequently the men continued the work one paving stone farther than he had stipulated. He was so enraged at the added expense incurred by her mistake that he refused to marry her.

He intended Guy's Hospital to be complementary to St. Thomas'. As a rule, no patient could remain in St. Thomas' for longer than four months, and they were discharged and sent home if they were judged incurable. This austere, forbidding, compassionate man, who was rumoured to starve his own employees and who could lose his temper over a matter of a few shillings, founded his great hospital as a sanctuary for those who had been abandoned as hopeless, and for the terrible sufferers discharged from Bethlem. Thomas Guy's statue stands at the gates of Guy's Hospital, a memorial to one of the most mysterious men who ever lived.

About the same time the first hospital supported by voluntary contributions was founded by a banker, Henry Hoare. It was called The Westminster Infirmary, and the first patient was admitted on May 11, 1720. It subsequently divided into two, the Westminster Hospital and St. George's, at Hyde Park Corner. Hyde Park Corner was chosen as the site of a hospital in order that patients might get the benefit of country air, and Knightsbridge was described as "good air for cure of consumption and melancholy and other infirmities".

The London Hospital originated from a conversation between seven gentleman in a tavern called *The Three Feathers*; they were led by a young surgeon of 22, and between them they mustered 100 guineas. At the first board meeting the treasurer reported a balance in the bank of one shilling, but help was forthcoming and the crisis averted. They outgrew their first premises and were forced to move; the lease of their vacated house was taken over by The Magdalen Hospital for the Reception of Penitent Prostitutes.

London's First Eye Hospital

London's first eye hospital was founded by a surgeon, John Cunningham Saunders, and his hospital is unique in being associated with a military campaign. In 1799 Napoleon invaded Egypt, and a year later, after the destruction of the French fleet at the Battle of the Nile, 1,800 British troops were landed in Egypt. By the time they were evacuated in 1803 many of them were suffering from Egyptian ophthalmia; when they returned to England the disease spread so rapidly through the population that a hospital for curing diseases of the eye became necessary, and Saunders founded the first hospital in the world for the treatment of eyes only. In 1822 land was purchased near Moorgate for the building of a new and larger hospital; the land was called Moorfields and the hospital became The Royal London Ophthalmic Hospital, Moorfields.

In 1827 Mr. William Marsden, the son of a corn chandler, founded the Royal Free Hospital with the motto 'Poverty and Sickness the only Passport required'. Before this no patient could be admitted to hospital without a subscriber's letter, and Mr. Marsden had witnessed the death of a girl of 18 found dying on the steps of a church, unable to get into any hospital;

A notice in the 'Illustrated London News' 100 years ago. The Westminster Hospital was founded in 1720 as 'The Westminster Infirmary'.

crossed, Messrs. Masterman, Mildred, Peters, and Co.
St. Mark's Hospital, City-road, London, Oct. 1854.

WESTMINSTER HOSPITAL, Broad Sanctuary, opposite Westminster Abbey.—During the recent epidemic 169 cases of Asiatic cholera were admitted into this Hospital, and 104 of the number were restored to health and to their homes and families. 3496 cases of diarrhœa were also received, and through prompt attention the further progress of disease was prevented. In addition to the above, more than 14 000 individuals, labouring under other forms of suffering, have been admitted during the present year, and out of that number 9656 cases of accident and urgent disease were received, at all hours of the day and night, without letters of recommendation This Hospital is entirely dependant on the contributions of the benevolent for support and as it is involved in a large outlay beyond its ordinary expenditure, the Committee earnestly appeal for aid to enable them to meet their liabilities.

Donations and subscriptions will be thankfully received by Messrs. Hoare and Co., 37, Fleet-street; Messrs Bouverie and Co., 11, Haymarket; by the Joint Treasurers, the Hon. P. Pleydell Bouverie, and P. R. Hoare, Esq.; or by the Secretary, at the Westminster Hospital.

F. J. WILSON, Secretary.

DR. DE JONGH'S
LIGHT BROWN COD-LIVER OIL, pre-

25 years later another doctor, Dr. Charles West, came to the rescue of a further section of the community—small children. Before he founded his hospital—The Hospital for Sick Children, Great Ormond Street—no children under the age of 10 were admitted to general hospitals. Of the 50,000 deaths recorded yearly in London, 21,000 were of children under 10—in January 1843, of the 2,363 patients in all the London hospitals, only 26 were children.

The doctor who successfully burgled his own hospital—the National Hospital for Diseases of the Heart—was Dr. Eldridge Spratt. For 15 years after the hospital's founding he fought a running battle with his successive committees, most of whom resigned in despair after a few months; eventually his behaviour became so outrageous that the committee were forced to the extreme step of dismissing their own founder. After his dismissal he paid one last visit to the hospital. He returned at dead of night with a furniture removal van and a gang of removal men; he removed from the hospital every portable object in sight, including an organ which somebody had presented, and drove off in triumph.

The last founder of the list, to whom the National Hospital for Nervous Diseases owes its being, was Miss Johanna Chandler. She was greatly distressed by her grandmother's death from paralysis, and determined to found a hospital for paralytics. She and her sisters learnt to make artificial flowers from small white shells ,and so hard did they work at this slave labour that they realized £200 in two years. It is pleasant to speculate on the reactions of visitors who found them at work. "Why are you doing that, Miss Chandler?" "Oh, we are going to found a hospital."

HERE and THERE

SMOKE ABATEMENT

The British Federation of Business and Professional Women recently submitted to the Ministry of Fuel and Power a resolution on smoke abatement, urging the Government "to take steps to ensure that ample supplies of smokeless fuel should be made available at a more reasonable price, thus enabling the domestic consumers to play their part in reducing air pollution." The Federation feels that the public is not yet fully aware that the domestic chimney contributes 50 per cent. to air pollution, and there is need of education so that domestic users can play their part in this vital matter. They point out that Mr. Arnold Marsh, O.B.E., Director of the National Smoke Abatement Society, is pleased to advise on publicity material and on the provision of speakers on this subject.

PAEDIATRIC NURSES TOUR

From Denmark, Northern Ireland, Scotland and England, sick children's nurses came to the Royal Hospital for Sick Children, Glasgow, for a splendid tour, arranged by the Association of British Paediatric Nurses, of Scottish children's hospitals, children's departments in general hospitals, nursing and medical schools in Glasgow, Ayrshire, Aberdeenshire and Edinburgh. The week's course was interesting, stimulating and educational. Psychiatrists, consultant physicians and surgeons, matrons, tutors, ward sisters, physiotherapists, dietitians, staff nurses and student nurses were included in the teamwork displayed.

Sunday, September 12, was spent in touring the enchanting Royal Deeside; the nurses arrived at Crathie Church, Balmoral, to see the Queen and other members of the royal household, who attended morning service.

A full account of the tour will be published in November on the Association's page in the *Nursing Times*.

OAKWOOD HOSPITAL, MAIDSTONE

The Mayor of Maidstone, Alderman A. H. Clark, who was accompanied by the Mayoress, opened the fifth annual flower show at Oakwood Hospital on September 18. Dr. R. Gordon McLaren, medical superintendent, said that there were 550 exhibits and, notwithstanding the difficult season for horticulturists, he understood that the standard was very high. At the conclusion, Dr. McLaren thanked the Mayor and Mayoress and also the judges and members of the Hospital Social Club who had done so much to make the show a success. Mrs. McLaren presented the prizes to the winners.

The annual show of the Oakwood Hospital Aquarists Society was held in conjunction with the flower show and cups were presented to the winners of first prizes in each class.

LONDON CIVIL DEFENCE CAMPAIGN

Some 300 men and women Civil Defence volunteers are taking part in a series of 25-mile drives through different areas of London, as part of a 30-day recruiting campaign for the Civil Defence service. In each borough on the route the Mayor reviews the 500-yard column as it passes the town hall or other key point. The 50 vehicles taking part include ambulances, mobile first aid units and rescue vehicles; the National Hospital Service Reserve will also be represented. The two remaining drives will take place on October 9 (S.W.) and October 23 (N.E.).

WESTERN PROVIDENT ASSOCIATION REPORT

In its report for 1953, the Western Provident Association for Hospital and Nursing Home Services, Ltd., Bristol, states that it is pleased to announce that its activities have developed so rapidly that in 1953 the Association's income was 41 per cent. in advance of that in 1952, and that there has been a still further advance during the first six months of the current year (up to June 30, 1954); that income, at £25,904, is 58 per cent. above the income for the corresponding period last year. This is a non-profit-making association for providing for its members and their dependants free or assisted specialist treatment and private hospital or nursing home maintenance at times of illness.

N.A.S.E.A.N. MEETING

A successful meeting which was supported by a number of members of the South East London Branch of the National Association of State Enrolled Assistant Nurses was held at 8, Monmouth House, Brockley, on September 20. The meeting concluded with refreshments which were provided by Miss Niramo.

HARLOW WOOD FETE

A combined effort of the nursing staff and committee of the friends of Harlow Wood Hospital was a garden fete which was opened by the Lady Mayoress of Nottingham, Mrs. A. Hobson; it was a great success. As a result of this effort the sum raised, after all expenses had been paid, was £314 towards the amenity funds for patients and staff.

SCHOOL HYGIENE

The Royal Sanitary Institute announces that an examination for its Certificate in School Hygiene will take place in London on November 19 and 20. This examination which, in the past, has been received with the greatest interest by teachers in all parts of the United Kingdom, provides a particularly valuable training for those seeking the additional responsibilities of headships. Successful candidates also qualify for election to Associateship which entitles them to use the designation A.R.San.I. Intending candidates can prepare for the examination by private study.

Copies of the examination regulations and syllabus can be obtained from the Secretary, Royal Sanitary Institute, 90, Buckingham Palace Road, London, S.W.1, to whom early application should be made.

ARMY NURSES

The undermentioned joined for first appointments as lieutenants in Queen Alexandra's Royal Army Nursing Corps on September 8, 1954.

Miss B. Anderson, Mrs. B. M. Anderson, Miss J. Cashin, Miss B. E. W. Crockett, Miss A. C. Crombie, Miss H. G. Cross, Miss H. Ferguson, Miss L. Garvey, Miss P. F. Green, Miss M. T. D. Green, Miss M. Hay, Miss M. M. Hill, Miss B. Ireland, Miss G. M. Jones, Miss E. M. Lee, Miss P. M. Merriman, Miss E. M. Molloy, Miss D. J. Moore, Miss K. O'Sullivan, Miss M. C. O'Sullivan, Miss S. J. Riddell, Miss M. Riley, Miss S. Richards, Miss I. M. Speight, Miss A. M. Thorne.

PUBLIC RELATIONS IN PHYSIOTHERAPY

The need for cultivating good public relations in the physiotherapy as well as in the rest of the hospital service is emphasized in a correspondent's letter in the August number of *Physiotherapy*. "In our department," says the writer," . . . we invite our patients' visitors. The work here is mostly concerned with poliomyelitis, so we have a considerable number of children, visitors being therefore mainly parents. We feel strongly that parents should be given some idea of the treatment given to their children daily. . . It is impossible for them to imagine the courage, perseverance and determination their own children put into exercises of all kinds, if they are only seen on Sunday afternoons safely tucked up in bed. . . If it has been desirable to have mothers visiting once a week they have been shown the exercises and carried them out themselves."

Headache

It is essential that those who suffer from recurrent headache should seek an explanation of its cause. Unfortunately there is often no obvious focus whose removal will effect a permanent cure and the patient must perforce rely upon symptomatic relief.

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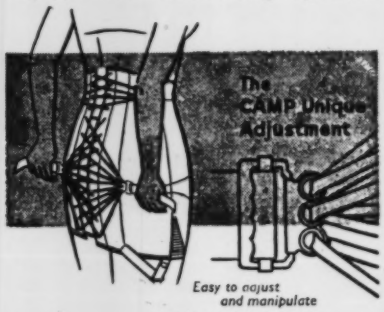

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Royal College of Nursing

The Nation's Nurses Regional Conference on Mental Nursing

MEMBERS of the nursing and medical professions and representatives of hospital management committees within the North West Metropolitan Region will consider the staffing of mental and mental deficiency hospitals and the training and best use of available personnel at a conference organized by the Royal College of Nursing, to be held at the Town Hall, St. Albans, Hertfordshire, on November 9 and 10.

Chairman: Miss F. M. C. Goddard.

Tuesday, November 9

STAFFING PROBLEMS AND THE BEST USE OF AVAILABLE PERSONNEL

9.30 a.m. Registration.
9.55 a.m. Chairman.
10 a.m. Speakers will examine the problems arising from the types of patients in the mental and mental deficiency hospitals at the present time and the effect on the nursing staff; the need for consultation and closer co-operation between nursing and other staff concerned with the treatment of the patient; the provision of non-nursing staff for non-nursing duties. Speakers will include medical superintendents, matrons and chief male nurses.
11 a.m. Coffee.
11.20 a.m. Group discussions.
12.30 p.m. Group leaders meet the chairman.
2.30—4 p.m. Group reports and questions.

Wednesday, November 10

TRAINING

10 a.m. Chairman.
10.5 a.m. Speakers will discuss what is required of the fully-trained mental nurse and whether the present syllabus meets that need; dual qualification and comprehensive training; training of auxiliary personnel. Speakers: a tutor (*The Syllabus*), a chief male nurse (*Dual Qualification and Comprehensive Training*), and a matron (*Training of Auxiliary Personnel*).
11 a.m. Coffee.
11.20 a.m. Group discussions.
12.30 p.m. Group leaders meet the chairman.
2.30 p.m. Group reports and questions.
3.45 p.m. Summary and conclusions.
4 p.m. Closing address.

Application for tickets should be made to the Conference Secretary, Royal College of Nursing, 1a, Henrietta Place, Cavendish Square, W.1. The fee is £2 2s. per person (including morning coffee). The conference is recognized for official study leave, and is open to those concerned with work in the mental hospital field *only*. Admission is by programme.

Branches Standing Committee

The quarterly meeting will be held in the Public Library, Vernon Road, Scarborough, on Saturday, October 23, at 10 a.m., by kind invitation of the Scarborough Branch.

Resolutions on the following subjects will be discussed: (i) recruitment of members to the Royal College of Nursing (Watford Branch); (ii) trained nurses' salaries (Newport Branch); (iii) terms for nurses suspended from work during contagious disease (Cardiff Branch); (iv) Branch representatives on Branches Standing Committee (North Western Metropolitan Branch); (v) chairs in Cowdray Hall (North Western Metropolitan Branch).

Education Department

HOME NURSES' REFRESHER COURSE

A refresher course for home nurses will be held in London from May 2-6 (inclusive) 1955. The course is non-residential, and the fee £3 3s. for non-members and £2 2s. for members of the College.

Sister Tutor Section

MARION AGNES GULLAN TROPHY CONTEST, 1954-55

The subject for the written part of the Marion Agnes Gullan Trophy Contest is: *Write an essay showing how social conditions have influenced the health of the community in the past and discuss the probable effect of the welfare state on the family and the individual.*

The size of the paper must not be larger than foolscap, and the entries should consist of not more than 2,500 words.

Forms of entry can be obtained from the Royal College of Nursing, and completed applications, marked 'Gullan Contest' in the top left hand corner of the envelope, should be returned to the Secretary, Sister Tutor Section, Royal College of Nursing, 1a, Henrietta Place, London, W.1, on or before November 28, 1954.

Public Health Section

Public Health Section within the Glasgow Branch.—Two films—*Public Health Nurse in America*, and *Starting Line*—will be shown at the Scottish Nurses' Club, 203, Bath Street, on **October 12**, at 7.30 p.m.

Public Health Section within the Liverpool Branch.—A general and quarterly meeting will be held at Radiant House, Bold Street, on **October 16**, at 10 a.m.

Public Health Section within the Plymouth and District Branch.—A Christmas bring-and-buy sale, to be opened at 2.30 p.m. by Mrs. H. Lawrence Spear, will be held at the Three Towns Nursing Association, Durnford Street, Stonehouse, Plymouth, on **Saturday, November 6.** Please come and bring your friends. Gifts may be brought on the day of the sale to Miss Sloman, 43, Thorn Park, or left at the Hall by Friday, November 5.

Occupational Health Section

Birmingham Group.—A general business meeting will be held on **Wednesday, October 13**, at 6.40 p.m.

North Eastern Metropolitan Group.—The next meeting will be held by the courtesy of Messrs. India Rubber Gutta Percha and Telegraph Works Co. Ltd., Silvertown, E.16, on **Tuesday, October 12**, at 6.30 p.m. Miss B. L. Morris will speak on *The International Congress on Industrial Medicine*. *Travel*: trains to Stratford, Plaistow, or Canning Town Stations; bus 669 to Silvertown Station from any of these points. Cross railway bridge—factory on right hand side; *or* trolley 569 from Aldgate to Silvertown Station.

Membership forms for the College may be obtained from the General Secretary, Royal College of Nursing, Henrietta Place, Cavendish Square, W.1, or local Branch secretaries.

Branch Notices

Ayrshire Branch.—A bring-and-buy sale and a business meeting will be held at Heathfield Hospital, Ayr, on **Wednesday, October 20**, at 7 p.m. All will be welcome. The sale is to augment Branch funds. Donations can be sent to Agnes I. C. Bone, Seafield Sick Children's Hospital, Ayr.

Belfast Branch.—An open meeting will be held on the third Tuesday of each month, except for December and February (the annual general meeting will be held on **Saturday, February 26**). All further details will be given in the *Nursing Times*. A meeting will be held at 6, College Gardens, on **Tuesday, October 19**, at 7.30 p.m., to discuss the agenda for the Branches Standing Committee meeting.

Bradford Branch.—A general meeting will be held in the Nurses Home, St. Luke's Hospital, on **Wednesday, October 13**, at 7 p.m. Please note: this meeting is instead of the one arranged in the Branch syllabus for Wednesday October 27. Agenda: to discuss the agenda for the quarterly meeting in Scarborough on October 23.

Bristol Branch.—There will be a meeting at the Bristol Eye Hospital on **Thursday, October 14**, at 6.30 p.m.

Dartford and North Kent Branch.—A general meeting will be held at Gravesend and North Kent Hospital on **Thursday, October 21**, at 7.30 p.m. A church service is being held in the hospital chapel on **Sunday, October 17**, at 7.30 p.m.; all nurses are welcome. A study day at Bexley Hospital has been arranged for **Wednesday, November 24**; full details later.

Isle of Wight Branch.—The next Branch meeting will be held at St. Vincent's, Binstead Road, Ryde, by kind permission of Miss Lee, on **Saturday, October 16**, at 3 p.m. Miss Moss will be the hostess. Mr. W. Roberts, M.A., will give a short talk on *The History of the Isle of Wight*.

Leicester Branch.—An executive meeting will be held at 96, New Walk, Leicester, on **Tuesday, October 12**, at 5.45 p.m., followed by a general meeting at 6.30 p.m.

Liverpool Branch.—A general meeting will be held in the Lecture Theatre, Royal Infirmary, on **Monday, October 25**, at 7 p.m.

Luton and District Branch.—A general meeting will be held at St. Mary's Hospital, Luton, on **Wednesday, October 20**, at 6.30 p.m.

North Western Metropolitan Branch.—There will be a general meeting at the Royal National Throat, Nose and Ear Hospital, Gray's Inn Road, W.C.1, on **Thursday, October 14**, by kind invitation of Miss Wade. At 8.30 p.m. Professor F. C. Ormerod, F.R.C.S., will address the meeting on *Different Types of Deafness*. *Travel*: King's Cross Station (Underground), then trolley 513 to hospital, or 7 minutes' walk; or to Russell Square Station, then 3 minutes' walk.

Oxford Branch.—An open meeting will be held at the Radcliffe Infirmary, Oxford, on **Thursday, October 21**, at 8 p.m. Mr. H. A. Goddard, Director of the Job Analysis Team will speak on *The Work of Nurses in Hospital Wards*; this talk will be followed by a discussion. Doctors, hospital administrators and members of the nursing profession are cordially invited to attend. Please notify Miss E. Farley, Churchill Hospital, Oxford, by October 14.

St. Albans Branch.—A general meeting to discuss the October Branches Standing Committee agenda will be held in the classroom, St. Albans City Hospital, on **Wednesday, October 13.** Bus 39A or 325 from St. Peter's Street to the hospital. Inquire at the lodge gates.

South Western Metropolitan Branch.—A Branch general meeting will take place at 7, Knightsbridge (Hyde Park Corner), on **Thursday, October 14,** at 8 p.m.

Tunbridge Wells and District Branch.—A lecture on *Modern Anaesthesia* will be given by Dr. Pelmore in The Kent and Sussex Hospital Lecture Room on **Tuesday, October 12,** at 8.30 p.m. All nurses will be welcome. A general meeting will be held at the Homoeopathic Hospital, Tunbridge Wells, on **Thursday, October 14,** at 2.30 p.m. It is hoped that all members will endeavour to attend.

Walsall and District Branch.—Miss Gaywood, an assistant secretary at the Royal College of Nursing, will be visiting the General Hospital, Walsall, on **Wednesday, November 10,** at 6.30 p.m., to talk informally with all the trained staff and discuss the work of the College. Please note the date. All trained staff welcomed.

Windsor, Slough, Maidenhead and District Branch.—A general meeting will be held at Upton Hospital, Slough, on **Tuesday, October 12,** at 7.30 p.m. The agenda for the October Branches Standing Committee meeting will be considered.

Worthing and South West Sussex Branch.—A meeting will be held at Southlands Hospital on **Wednesday, October 20,** at 8 p.m., to discuss resolutions for the Branches Standing Committee meeting. Subscriptions are now due.

NURSES APPEAL

Nation's Fund for Nurses

Donations are given at the cost of personal sacrifice and I take this opportunity of thanking all who have contributed for the service they have rendered; as time goes on it is hoped that more financial assistance will be given for those retired nurses who must never be forgotten. It has been a privilege to do this work and although there is always an element of sorrow in doing anything for the last time, I am happy to know that the future of this good cause is bright with promise in the hands of my successor, Miss E. F. Ingle.

Contributions for week ending October 2

	£	s.	d
Miss E. M. Slack		5	0
Miss E. Forbes Sutcliffe		10	0
Miss V. M. Clarke		5	0
Nursing Staff, General Hospital, Cheltenham	1	5	0
C.E.A.S.	5	0	0
Miss E. B. Ironside		5	0
Westminster Children's Hospital	1	1	0
Minehead and West Somerset Hospital. Raised by a jumble sale	15	15	0
Chelsea Hospital for Women	1	0	0
Royal Berkshire Hospital, Reading. *Monthly* donation		10	0
Total	**£25**	**18**	**0**

W. SPICER,
Secretary, Nurses Appeal Committee, Royal College of Nursing, Henrietta Place, Cavendish Sq., London, W.1.

General Nursing Council Elections

In view of the election of members of the General Nursing Council for England and Wales which is due to take place in 1955, registered nurses are asked to notify any change of *permanent* address without delay to the offices of the Council, 23, Portland Place, London, W.1.

Study Days, Weekends and Conferences

Occupational Health Section, Birmingham Group, Annual Conference

The annual conference of the Birmingham Group will be held at I.C.I. Limited, Metals Division, Witton, Birmingham 6, on Saturday, November 20.

The Nurse as a Health Educator, by Dr. John Burton, medical director, Central Council for Health Education.

Coffee.

The Nurse as a Health Educator, by Dr. Emrys Davies, education officer, Central Council for Health Education.

Lunch.

The Changing Pattern of Mortality for Respiratory Tuberculosis, by Dr. Charles R. Lowe, lecturer in Public Health Department, Social Medicine, University of Birmingham.

The Surgical Treatment of Pulmonary Tuberculosis, by Mr. A. L. d'Abreu, O.B.E., director of thoracic surgery to the Birmingham Regional Hospital Board.

Tea.

The programme, with details, is obtainable from Miss H. M. Postons, 26, Lower White Road, Quinton, Birmingham 32. Applications must be received not later than Wednesday, November 10.

Thanet Study Day

The Thanet Branch is holding a study day at Princess Mary's Hospital, Cliftonville, Margate, on Saturday, October 30. Chairman: Miss M. L. Wenger, S.R.N., S.C.M., Diploma in Nursing, University of London, Editor, *Nursing Times.*

10 a.m. Registration.

10.30 a.m. *The Treatment of Heart Disease, Ancient and Modern,* by Dr. J. M. Lipscombe, M.D.

11.30 a.m. *Gastro-enteritis in Babies and Children,* by Dr. T. S. Rodgers, M.D.

12.45 p.m. Lunch interval. Tea or coffee will be provided for those bringing sandwiches.

2.30 p.m. *Mental Illness,* by Dr. F. L. Scott.

3.30 p.m. *Poliomyelitis,* by Dr. J. V. Armstrong, M.D.

Afternoon tea will be provided in the Nurses' Home at Princess Mary's Hospital.

Applications should be made to Miss Duncan, matron, Princess Mary's Hospital, Cliftonville, Margate, by *October 26.*

Fees. College members 2s. 6d. the day, 1s. 6d. the session; non-members 4s. and 2s. 6d.; student nurses free.

Southampton Study Day

Southampton Branch will hold a study day at Tremona Court, Southampton School of Nursing, Tremona Road, Southampton, on Saturday, October 23.

9.15 a.m. Registration.

9.30 a.m. *Surgery in General and Post-operative Care,* by S. N. Lytle, Esq., consulting surgeon. Chairman: Miss M. A. Chick, S.R.N., S.C.M., H.V.Cert.

10.30 a.m. Coffee.

11 a.m. *Tuberculosis,* by Dr. W. M. McLeod, M.B.E. Chairman: Mrs. D. Bond, S.R.N., S.C.M.

12.45 p.m. Lunch at Tremona Court.

2.30 p.m. *Radiotherapy,* by Dr. J. K. Morgan, M.R.C.S., L.R.C.P., D.M.R.T. Chairman: Miss P. E. Pain, S.R.N., S.C.M.

4 p.m. Tea.

Fees. Full day (including meals): College members 7s., non-members 8s. Morning session (lectures and lunch inclusive): members 4s. 6d., non-members 5s. Afternoon session (lecture and tea): members 2s. 6d., non-members 3s. Applications should be sent to Miss M. Sturgess, hon. treasurer, The General Hospital, Southampton, not later than Tuesday, October 19, enclosing remittance; please indicate meals required.

Travel: bus 7 or 9 from Central Station or Civic Centre, alight at Tremona Road.

Cumberland Study Weekend

Cumberland Branch will hold a study weekend at Cumberland Infirmary, Carlisle, by kind permission of matron, and at the Courts, Carlisle, by kind permission of the Clerk of the County Council, on Friday and Saturday, October 8 and 9.

Friday, October 8 — *The Cumberland Infirmary.*

10.30 a.m. Opening by J. L. Bond, Esq., assistant director of education, Cumberland County Council.

11 a.m. *Poliomyelitis,* by T. C. Studdert, M.D., M.R.C.P. *Chairman:* J. L. Bond, Esq.

2 p.m. Visits to the Geriatric Unit, City General Hospital, Carlisle, or to a local factory, to be arranged.

5.30 p.m. *Geriatrics,* by O. Olbrick, M.R.C.P., F.R.C.P., Ph.D., consultant physician, General Hospital, Sunderland. *Chairman:* D. Cameron, M.D., F.R.F.P.S., consultant physician, Cumberland Infirmary.

Saturday, October 9—*The Courts, Carlisle.*

10.30 a.m. Opening by G. N. C. Swift, Esq., Clerk of the County Council.

11 a.m. *Visits to American Hospitals,* by Miss K. A. Raven, S.R.N., S.C.M., matron, General Infirmary at Leeds. *Chairman:* G. N. C. Swift, Esq.

2.30 p.m. *Burns in Children,* by A. McDowall, T.D., F.R.C.S., consultant plastic surgeon, Booth Hall Hospital, Manchester. *Chairman:* A. Bruce MacLean, M.B., Ch.B., F.R.C.S., F.R.F.P.S., assistant consultant surgeon, Cumberland Infirmary.

5 p.m. Brains Trust. *Chairman:* R. S. Venters, M.B., Ch.B., F.R.C.S., senior consultant ear, nose and throat surgeon, East Cumberland Hospital Management Committee.

At the Courts there will be an exhibition on health education and the work of local authority health departments.

Fees. *Complete course:* members 5s., non-members 6s. *One day only:* members 2s. 6d., non-members 3s. *Single lectures:* 1s. 6d., student nurses 9d.

Coffee will be served before the opening each day at 10.15 a.m. Tea will be served between the two afternoon lectures.

Obituary

Miss H. R. Bett

We regret to announce that Miss Helen Rodger Bett died at St. Andrews, on September 14. Miss Bett trained at the Royal Infirmary, Edinburgh, and the Royal Maternity Hospital, Glasgow. She was appointed to the staff of the Royal Maternity and Simpson Memorial Hospital, Edinburgh, and was there for a number of years. From 1910-15 she was matron of the Maternity Hospital, Loveday Street, Birmingham. In 1915 she returned as matron to the Royal Maternity and Simpson Memorial Hospital, Edinburgh. Many nurses will remember Miss Bett with gratitude and affection.

Student Nurses' Association

AREA SPEECHMAKING CONTESTS

Above: *a group after the Western Area Contest at Princess Elizabeth Orthopaedic Hospital, Exeter.*

Left: *Miss J. E. Purcell, the winner, with contestants at the Manchester Royal Infirmary after the Northern Area (West) Contest.*

Northern Area (West)

THIS year the contest was held in the Great Hall of the new nurses home, Manchester Royal Infirmary, by kind permission of Miss Duff Grant, matron.

The subject was *Responsibility*—the watchword which Miss Gerda Höjer, retiring President of the International Council of Nurses, gave to all members for the next four years, when the Quadrennial Congress was held in Brazil in 1953.

The winning competitor was Miss Joyce E. Purcell, of St. Helens Hospital, St. Helens, and the runner-up Miss Claire Thomas of the Royal Manchester Children's Hospital, Pendlebury. Twelve competitors took part.

Before the contest in the afternoon, a visit to Manchester Central Library proved to be most interesting and gave us a greater understanding of the work carried on in this building.

I would like to take this opportunity to thank Miss Duff Grant and her colleagues for the kind hospitality which was shown to us at her hospital, and to the Lady Mayoress, Mrs. R. S. Harper, who presided, and to all those who helped in any way to make the day a successful and happy occasion.

I. W. H. WILD.

Western Area

THE Western Area Speechmaking Contest was held this year on Saturday, September 25 in Exeter. Students from all parts of the area arrived overnight, coming from as far away as Carmarthen and Northampton. By a feat of organization on the part of the administrative staff, 16 were accommodated in the Royal Devon and Exeter Hospital and entertained by the Student Nurses' Association Unit.

On Saturday morning a party of student nurses were taken round Exeter Cathedral by the Rev. Houliston. This was no ordinary tour; they were specially privileged and taken up the towers, on to the roof and into the belfry, and able to see the landmarks of South Devon on a clear autumn morning from the wonderful viewpoint of the Cathedral roof.

After lunch a large audience of visitors and students met at the Princess Elizabeth Orthopaedic Hospital to hear the Contest. The Very Rev. Alexander Wallace, Dean of Exeter, took the chair and welcomed candidates and audience, and delighted them with a contrast of the old style of approach and our modern, rather brisk but efficient way. The Dean introduced the adjudicators, who were Mrs. Sylvia Sayer, chairman of the Dartmoor Preservation Society, Mrs. Vera Lloyd, L.R.A.M. (speech and drama), lecturer in English phonetics at the University College, Exeter, and Miss Ann White, county nursing officer for Cornwall, and member of the Area Nurse Training Committee for the South West Region.

The Contest—Objects and History

The area organizer, Miss M. Baly, gave a brief resumé of the objects of the Contest and its history, stressing the importance of nurse leadership and of nurses being willing and able to carry the burden of their own affairs and not to leave them to others. The Contest not only encouraged nurses to speak well but, by choosing a subject removed from nursing, it also encouraged them to think on some aspect of citizenship. An eminent surgeon had said it took three years to train a nurse and another seven to teach her to think for herself—we would like to see that process hastened. Miss Baly said the organization of the Contest had been unusually easy this year because there had been such a high degree of co-operation in Exeter, and on behalf of the Student Nurses' Association she thanked Miss J. Leiper, the matron of the Royal Devon and Exeter, and Miss G. Edge the matron of the Princess Elizabeth Orthopaedic Hospital and their staffs for all the trouble they had taken. Furthermore the response from visitors and students had been better than ever; 16 units were at the Contest that day, and many more had written wishing to come but for some reason had not been able to.

The subject was *An untidy generation is leaving its hallmark on the countryside in quantities of litter*, and there were 10 candidates. Litter is a subject near to the heart of the inhabitants of the beauty spots of the West, and all the candidates saw it as a menace of modern times, the trail that lies in the wake of more travel, more and more wrapped food, more ices and toffees, not to mention the rather larger salvage that visitors sometimes leave in their track! Nearly all the competitors urged the need for better education on the subject and early training; one at least had the grace to confess that the occupants of the student nurses' sitting-room might not be paragons of all the virtues of tidiness! Stricter supervision and heavier fines were also put forward to combat the problem, and better and more waste paper baskets.

Criticisms and Comments

The adjudicators gave helpful criticism to each of the candidates. Mrs. Sayer was particularly interested in the content of the speeches and the constructive thought behind them; she congratulated the candidates on the amount of preparation they had given to the subject. Mrs. Lloyd in criticizing the delivery urged the candidates to speak from a few headings rather than trying to memorize the whole speech; most of the speakers had pleasing voices, but some had to learn the value of the natural pause. Miss White commented on the qualities she would welcome in a person she would like to have on a committee; the approach and the effect of the personality on the audience were important—some candidates had not paid sufficient attention to these points.

The winner was Miss Sylvia Smith from Swansea General Hospital whose speech had undoubtedly all the merits. It was spoken with conviction and without faltering while the content was constructive and well thought out. The runner-up was Miss Thusnelda Necker, student from East Germany and a most refreshing speaker, whose humour was very mature and who knew the value of a pause. She had the courage to attack the statement, reminding us that our ancestors were not guiltless and had some very unsavoury methods of getting rid of their rubbish!

Mrs. C. Birkett, J.P., chairman of the Mid-Devon and Exeter Management Committee, in presenting the cup to Miss Smith said how delighted she had been with the speeches and how she wished that some of the people on her committees spoke as well.

Miss Smith thanked Mrs. Birkett, the Dean and the adjudicators but recorded her very special thanks on behalf of the students to the matrons of the Exeter hospitals—some visiting students had had their breakfast in bed! Miss Necker

vindicated the adjudicators' choice in her thanks, and thanked Miss Baly for locking her notes in the car so that she had had to speak extempore! So the cup goes to Swansea to join the Cates shield; the mantle of the Welsh orators certainly seems to have fallen on Swansea General Hospital.

Tea was served to the visitors in the nurses home. In making a final tour of the hall it was felt that the 10 homilies on litter had been effective—there was not so much as a single matchstick!

Coming Events

British Social Biology Council.—The Joint Biology Committee is holding a conference on *Endocrinology* at County Hall, London, on Saturday, November 13. A discussion will follow the main address. Fee: 6s. Application should be made as early as possible to the secretary, Joint Biology Committee, c/o British Social Biology Council, Tavistock House South, Tavistock Square, London, W.C.1, from whom further particulars may be obtained.

German Hospital, Dalston, E.8.—The graduation and presentation of certificates will be held on October 12, at 2.30 p.m. The Lord Bishop of Stepney will officiate at the ceremony of distribution of certificates. Matron will be delighted to receive past members of the nursing staff. R.S.V.P.

Hillingdon Hospital, Uxbridge, Middlesex.—The nurses annual prizegiving will be held on Tuesday, October 19, at 3 p.m. Past members of the staff are cordially invited. Hospitality for the night can be arranged if desired. R.S.V.P. to matron.

National Association for Mental Health.—Dr. A. Querido, Professor of Social Medicine, University of Amsterdam, and Director, Amsterdam Public Health Service, will speak at a public meeting organized by the Association to be held at William Beveridge Hall, Senate House, Malet Street, W.C.1, on Friday, October 22, at 5 p.m.

National Council of Nurses of Great Britain and Northern Ireland.—There will be a meeting of the Grand Council in the Riddell House Nurses Home, St. Thomas' Hospital, London, S.E.1, on Thursday, November 25, at 2.30 p.m. The meeting will be preceded by a Service at 2 p.m. in the hospital chapel when Dr. Don, the Very Reverend Dean of Westminster, will give the address. The agenda will include the President's address, result of the election of president, vice-president, hon. secretary, hon. treasurer, directors (2), and the report of the Florence Nightingale National Commemoration Day.

Oldchurch Hospital, Romford.—The reunion and prizegiving will be held on Wednesday, October 27, at 3 p.m. Past members of the staff are cordially invited. R.S.V.P. to matron.

Royal Salop Infirmary Nurses' League.—A sale of work in aid of League funds will be held on Saturday, October 30, at 2.30 p.m. All donations and contributions would be most gratefully received by matron.

Royal Sanitary Institute.—Birmingham meeting. *The General Practitioner and Local Authority Personal Health Services*, by (*a*) A. Beauchamp, M.B., Ch.B., a general practitioner, (*b*) a health visitor, and (*c*) a clinic medical officer; also a paper on new food legislation; in the Council Chamber on Thursday, October 21, at 10 a.m. Joint hon. local secretaries: Dr. Jean M. Mackintosh, administrative medical officer of health, Maternity and Child Welfare, Birmingham, and Dr. W. R. Martine, O.B.E., T.D., administrative medical officer of health, Birmingham.

NOTES FROM KENYA

We publish below extracts from a letter written by an overseas member of the Royal College of Nursing, Mrs. Duncan Wilson (née C. M. G. Campbell), who since her marriage has been living in Kenya. Such news from readers abroad, telling us of their lives and interests, is always welcome.

"IN our area we are so far comparatively free from Mau Mau activity, but there are some of the Kikuyu tribe in the Province and oath ceremonies have taken place. Some friends of ours discovered that their cook was an oath administrator and he has been sent to jail—a servant they have had for 30 years, who was born on the place, but various oaths would make it necessary for him to kill his master and family if ordered to do so. They are so bound by the oaths that they dare not go against them—it is really the old witchcraft at work still and it is this superstition that is the real enemy. It is all very sad.

Our farm workers keep very well on the whole, but recently I have picked out one with pulmonary tuberculosis and another with a tuberculous abscess of the axillary glands. Both these Africans developed the disease before coming to work for us. They lead a very open-air life, which helps a great deal. Very occasionally now we have one or two getting malaria, but that is not so prevalent as it was about 10 to 15 years ago. If they get a swelling or soreness of a limb they don't report for some time and use their remedy of slashing the skin over the affected area to let the 'badness' escape!

As I have a small baby, my husband will not allow me to attend any who fall sick at present, but when she is a lot older I hope to have a small clinic for our farm labourers and the one or two adjoining farms. But once the word goes round that anyone has been 'given a needle' (a penicillin injection) they *all* want what they call a *sindani* (in their own language). A friend of ours, who is also a trained nurse, has a clinic—for the Red Cross—some miles from here and she is in quite a busy area as there are several farms near them and they are on the main road too. She has a family of six, and one day an African came and asked her to give his wife a *sindani* so that she could have children! When my friend said she couldn't help her with an injection, he would not believe her—for, as he pointed out, she had six *m'totos* (children)! She has a lot of cases and has dealt with several snake-bites and a case of poliomyelitis and unfortunately a good many cases of venereal disease.

We are now at the beginning of our long rains, everywhere is so fresh and green and the maize crops are well away; already this month we have had over seven inches of rain. Our average for a year is 65 inches, quite often a third of that falls in one month. The roads get very muddy—no tarmac—and cars get stuck and then either oxen or tractors have to be used to pull them out."

Mrs. Wilson enclosed with her letter some copies of the East Africa Women's League *Newsletter*. These are written by various residents in the Colony and printed on Air-letter forms for private circulation with a view to presenting responsible, first-hand reports of the situation in Kenya, and something of the causes lying behind the troubles there.

ST. GEORGE-IN-THE-EAST HOSPITAL OPEN DAY

A VERY successful open day was held at St. George-in-the-East Hospital, London, E.1, on September 23. Wards and departments were open and nearly 300 visitors were welcomed by Miss R. E. Finch, matron, Dr. J. H. Duke, medical superintendent, and Mr. A. D. Bermel, chairman of the hospital; they were conducted round the hospital by the assistant matron and senior nursing staff.

There were exhibitions and demonstrations in the preliminary training school, casualty department, pathological and X-ray departments, and the physiotherapy and occupational therapy departments. A great attraction was an exhibition of patients' handicrafts made in the occupational therapy department. An outstanding feature by students of the preliminary training school was the presentation of models, made by the student nurses, as tableaux depicting the history of nursing. Much credit is due to all staff who were responsible for the exhibitions and demonstrations, which the visitors found so interesting, and after the afternoon session some of them returned to see it all again in the evening.

A Film Made at the Hospital

Another highlight was a colour film made at the hospital, *A Nursing Story*, which showed the various duties undertaken by student nurses during their training. This film was shown to several 'houses' in order to accommodate all the spectators who wanted to see it.

After the evening session Mr. A. D. Bermel welcomed the guests to a meeting and explained the object of the open day, which was to arouse interest in the hospital's League of Friends, run by a committee to procure extra comforts for patients which cannot be provided by the Health Service. He hoped for many new subscribers.

Miss Finch then gave a short talk on the early history of the hospital and said that it was one of the first four infirmaries in the country to become a hospital and a training school for nurses. As nurses they knew what a responsibility they had to their local people and they wanted to give them the very best nursing care and every consideration when they were patients; but also, said Miss Finch, they wanted to do so much more than that to make their stay in hospital happy and she explained the kind of things on which the money could be spent. She told the audience that the inspiration to start the League of Friends came from a patient who had given £80 worth of savings certificates to the hospital in gratitude for the care he had received.

Mr. Gibson, a member of the committee, then described St. George-in-the-East Hospital as a "citadel of light and healing". "It is a happy place", he said "and our patient get expert attention, but we still want to do the little extra for them".

OFF DUTY

At the Cinema

The Belles of St. Trinian's

This farce concerns a girls' school and a race horse, a bookmaker and his sister (headmistress of the school) and a gang of pupils and mistresses that beggar description! It is, of course, preposterous from start to finish but one is kept in a state of giggles. Alastair Sim doubles the parts of bookmaker and headmistress. Joyce Grenfell, George Cole, Hermione Baddeley, Betty Ann Davies and Renée Houston also take part.

Bow Bells is a short feature film of London, its people and activities which is both interesting and very appealing. This is shown in the same programme as *The Belles of St. Trinian's.*

For Better, For Worse

A young couple coping with married life in a one-room flat on the 'never-never' and £4 10s. a week is the basis of this film. Much of the dialogue is extremely funny. Dirk Bogarde, Susan Stephen, Cecil Parker, Eileen Herlie, Athene Seyler, Dennis Price, James Hayter and Sidney James all sparkle.

Cinerama

Interesting, yes, noisy—very! This film has no story and no stars, but the scenes are in beautiful colour and very varied—Venice, Edinburgh, Milan and a long sequence of aquatic sports, etc. Three separate projections are thrown on to the huge screen; but while the centre panel is steady the two wings have a tendency to waggle up and down, which is worrying. It is well worth a visit.

On the Waterfront

The story of the racket-ridden dockland of New York and of a young man who, without much thought of where he is drifting, gets involved with a terror gang. It is a tough film very well done and acted. Starring Marlon Brando, Karl Malden, Lee J. Cobb, and Eva Marie Saint.

Sabrina Fair

Daughter of the chauffeur of a very rich family, Sabrina is sent to Paris to take a two-year course at a cookery school—she learns much else besides and comes back to cause trouble with the two sons of this family. A gay triangle comedy with plenty to laugh at. Starring Humphrey Bogart, Audrey Hepburn and William Holden.

Romeo and Juliet

The story of the star-crossed lovers takes 2 hours 18 minutes to tell, and one is utterly unaware of the passing of time. The colouring is soft and natural and the Italian settings most beautiful. Laurence Harvey and Susan Shentall both have great charm; the nurse of Flora Robson and the Friar of Mervyn Johns are outstanding. It is a very fine picture.

At the Theatre

THE PARTY SPIRIT, *by Peter Jones and John Jowett* (*Piccadilly*).

The 'party spirit' is nominally that animating politics, but, as may be expected from the presence in the cast of Robertson Hare, Ralph Lynn and Vera Pearce, it smacks a great deal more of highly convivial occasions than of the staid proceedings of the Mother of Parliaments in the precincts of which the scene is set. William Grout, M.P., (Robertson Hare) finds himself the leader of a party of two—the 'Free Whigs'—his 'following' consisting of Leonard Bilker, M.P. (Ralph Lynn) whose behaviour in the House is as dubious as the means which, it is hinted, he has used to arrive there at all. The Free Whigs find themselves in a key position, for each of the traditional parties woos them for the casting vote which they can exercise for the downfall or the triumph of the Government in a critical division. This results in a highly scandalous partnership (a more appropriate word than *party*) of Grout and Bilker to sell their votes to the highest bidder—either for cash or for favours to come, and the fun waxes fast and farcical.

The audience relish one or two caricatures of current political personalities and events, and the talented team rollick undaunted through the slapstick absurdities of a riotous farce. Vera Pearce takes full advantage of an excellent part as Mrs. Violet Binder, M.P. Margot Lister, as Mabel, barmaid in the Strangers' bar, has a small character part which she plays admirably.

MOORHAVEN HOSPITAL, PLYMOUTH

Open Day

TO help combat the prejudice against mental hospitals, Moorhaven Hospital, Plymouth, holds an annual open day when the hospital is open for inspection by the local citizens. Judging by the numbers attending this has become a popular local event.

On September 22 at 3 p.m., the visitors assembled to hear the report of the medical superintendent, Dr. F. Pilkington, and the guest speaker, Mr. Kenneth Robinson, M.P. for St. Pancras and member of the North West Metropolitan Regional Board. Dr. Pilkington presented an encouraging picture of steady improvement, though much-needed alterations and extensions were still hampered by lack of money. The kitchen had been modernized and a providential fall of the ceiling in the main hall had enabled them to make a great improvement in that quarter. The changed position in the mental hospital was revealed in his comment that 90 per cent. of the patients in Moorhaven were not certified, the average stay was six months, and 75 per cent. left the hospital either recovered or improved.

Revolution in Mental Health

Mr. Robinson, who is well-known to nurses for his efforts in the House of Commons on behalf of mental health, drew a graphic picture of the revolution in the mental health services during the past 25 years, a revolution that has been brought about partly by the growing recognition of human dignity, and partly by the changed methods of treatment and by the change in the public attitude. Not so long ago we spoke of the mentally ill as being 'put away'. The mental hospital had changed from the static to the dynamic. The handicaps to progress were overcrowding, which was endemic to the extent of 15 per cent., shortages of nursing staff, old-fashioned buildings that were so stoutly constructed that they withstood the depredations of war and time, the lack of money and the public attitude.

Mr. K. Robinson, M.P., member of the North West Metropolitan Regional Hospital Board, is shown the new admission block which is being built at Moorhaven Hospital.

Mr. Robinson urged the people to accept the mental hospital as part of their community just as they accepted the general hospital, and he drew a spontaneous round of applause when he said that there was no reason why disease of the mind should be regarded in a different light from disease of the body.

Alderman Mrs. Marshall, a well-known Devonian figure, who has spent 30 years in service to the Plymouth hospitals, as chairman of the Moorhaven committee thanked Mr. Robinson, recalling days gone by when boots and clothes never fitted and when 'occupational therapy' was floor scrubbing. She reminded Mr. Robinson that what they needed most was money, and she urged him to continue his efforts in the House of Commons and to persuade the Chancellor of the Exchequer to be a little more liberal to the Ministry of Health in order that there might be more for the mental hospitals where money was so desperately needed. Mrs. Marshall also mentioned how much the hospital was missing Miss Davison, the matron, and how deeply grieved they were by her serious illness.

After the meeting all the visitors were entertained to tea in the hospital grounds which command a wonderful view of the rolling countryside of South Devon, the peace and quiet of which should bring balm to the hurt mind.

NURSING APPOINTMENTS OFFICES

During 1953, the 140 Nursing Appointments Offices in the country placed 9,793 men and women in whole-time posts and 1,287 in part-time posts. At the end of the year, however, there were 23,440 unfilled vacancies (including those for 10,375 student nurses) though this was slightly less than at the end of 1952. Nearly 45,500 interviews were given to those who sought advice.